

Final report on symphysiotomy in Ireland, 1944-1984

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Report on Symphysiotomy in Ireland, 1944-1984

Overview:

This Final Report is the culmination of a two-stage process aimed at fulfilling the request of the previous Minister for Health and Children (Mary Harney) in relation to the practice of symphysiotomy in Ireland. This first phase was an independent academic research report. The second phase involved consultation with relevant stakeholders to provide comment on the report. The first section of this Report comprises the draft report which was compiled with reference to printed sources, and the analysis of medical reports and research. This first stage did not involve interviews with individuals directly involved in symphysiotomies (mothers, practitioners and midwives in particular). This approach was central to the production of an independent report, compiled without influence or input from vested interests. Once the independent baseline was established, the researcher sought feedback from the stakeholders, and further input from those with direct experience in the procedure. From the announcement of this project, the author had unsolicited contact from various individuals with experience of the procedure, offering their perspectives. None of these offers of assistance were followed up, in order to ensure that the Draft Report remained free from influence from either proponents of the procedure, or opponents of it. Once that phase was complete, the author sought additional input in order to ensure that the present Final Report reflects as accurately as possible the history of symphysiotomy in Ireland (see consultation process below). This Final Report is in two sections: the first includes the findings of the Draft Report, which includes the academic study of symphysiotomy and its revival in Ireland. The second section includes the findings of the phase two, consultative process.

Section One.

Note on Focus of the Draft Report:

The report focused on the years 1944 to 1984, the period in which symphysiotomy was employed in some Irish hospitals. The years of most significant use were from the late 1940s to the 1960s, when the operation was largely superseded by Lower Segment Caesarean Section as a response to obstructed labour. The draft report draws heavily on the position in Dublin, and in Our Lady of Lourdes Hospital in Drogheda, given the particular concerns expressed regarding practice there. These hospitals produced periodic annual reports, with specific detail regarding symphysiotomy and its uses. The national picture is far less clear.¹ Most maternity hospitals did not produce annual reports, and the survival of individual maternity registers, and indeed patient medical charts, varies from region to region. At this stage it is important to identify the prevalence of the procedure from the 1940s to the 1980s on the basis of available figures. A figure of 1,500 symphysiotomies has been suggested for the period 1944-1992². Preliminary figures from regional maternity hospitals suggest the usage was a good deal lower than in the capital, and the procedure does not appear to have been used at all in some centres. 1,500 symphysiotomies between 1944 and 1992 gives a rate of 0.05 as a percentage of total deliveries, or a symphysiotomy rate of 60 per 100,000 births.³ Thus it was a rare intervention in comparison with caesarean section, for example, which rose steadily in the same period from a rate of just under 2% of deliveries in 1944 to over 4% nationally in 1984. This is not in any way to minimise the suffering of the women who underwent the operation, but it does indicate its exceptionalism in Ireland as a whole.

Methodology:

The study set out to establish accurate rates of usage of symphysiotomy in Ireland as a whole, and to compare its use in other European countries in the second half of

¹ Although individual hospitals have been helpful with regard to gathering statistics there are significant problems. Not least of these is the fact that few hospitals compiled annual reports in the mid-twentieth century, and recovering detail on specific operations requires hand searches of data on operations undertaken, and the consultation of case notes, which is outside the terms of reference of this report.

² Marie O'Connor, *Bodily Harm: Symphysiotomy and Pubiotomy in Ireland, 1944-92*, 'Executive summary', p. 12.

³ There were 2,527,896 births in the Republic of Ireland between 1944 and 1992 inclusive. Central Statistics Office, Vital Statistics, Births by State, Year and Statistic, 1944-1992.

the twentieth century. Searches were undertaken of databases relating to maternal care in Britain, Spain, Germany, France, and Italy, as well as OECD world-wide material. Requests for information were also made to repositories and national records systems in each of these countries. Printed primary sources in Ireland were checked, including Department of Health files in the National Archives, and Annual Reports in the National Library. All of the Irish public maternity hospitals were contacted to determine the availability of statistics relating to rates of the procedure.⁴ The Central Statistics Data on Health and on maternity care was examined. A comprehensive secondary literature review was undertaken using searches of PubMed and Medline, as well as hard copy searches of mid-twentieth century medical journals held at University College Cork and the National Library, Dublin.

Limitations of Available Sources:

In Ireland and abroad it has proved very difficult to secure accurate figures regarding the use of symphysiotomy (see final section for further clarification as a result of the second phase of the process). From the early twentieth century, when the technique was adapted by Zarate to prevent the complete division of the pubic symphysis, the procedure was employed throughout Europe, albeit in small numbers relative to overall deliveries. However, as maternity hospitals were not required to produce annual reports, evidence of usage is often anecdotal, and no firm statistics are available. There has never been a randomised trial of symphysiotomy (one of the standards for the evaluation of a medical procedure) in any country, although there is a substantial body of medical literature on its use in specific hospitals and regions worldwide (see bibliography). Britain was originally chosen as a comparator in this study, and searches of the National Health Service Health and Social Care Information Centre database, and the British Department of Health Hospital Episode Statistics were undertaken. No results for symphysiotomy were found,⁵ although the

⁴ Cork University Maternity Hospital; Kerry General Hospital, Tralee; South Tipperary General Hospital; St Luke's General Hospital Kilkenny; Waterford Regional Hospital; Wexford General Hospital; Galway University Hospitals; Letterkenny General Hospital; Mayo General Hospital, Castlebar; Portiuncula Hospital, Ballinasloe; Sligo General Hospital; Mid Western Regional Maternity Hospital Limerick; Cavan/Monaghan Hospital Group ; Midland Regional Hospital Mullingar and Midland Regional Hospital Portlaoise.

⁵ In common with other European countries, including Ireland, Britain's searchable statistics cover the relatively recent past. The Hospital Episode Statistics (HES) begin in 1989, and do not cover all procedures.

procedure was in fact employed sporadically throughout the UK after 1945,⁶ and periodic discussions took place in the medical journals regarding a possible revival of the procedure in the face of a rising caesarean section rate.⁷ Staff in the NHS records departments also undertook searches, without success. The material compiled by the Royal College of Obstetricians and Gynaecologists in London is too recent to include symphysiotomy, and searches of their historic statistics have shown no mention of the procedure.⁸ However, a 2003 article in the *British Journal of Obstetrics and Gynaecology* describes three recent British cases, and argues for the use of the procedure in certain carefully selected deliveries.⁹ As there is a strong connection between the use of symphysiotomy and an acceptance of Catholic precepts regarding contraception and sterilisation, data from Spain and Southern Germany was examined for rates. There are no available figures for use in the second half of the twentieth century in the health statistics of the Instituto Nacional de Estadística, although the procedure was the subject of an article in Spain, published in 1955, which described its use in 27 deliveries.¹⁰ It appears to have been used in Spain as late as 1953, when an article describing its use in emergency breech deliveries in 259 cases (between 1927 and 1953) was published.¹¹ Symphysiotomy was employed in deliveries in the predominantly Catholic Southern Germany in the first half of the century, but there are no available statistics for its use after 1945 in the Statistisches Bundesamt Deutschland, or in the databases available through the German Federal Health Monitoring System. Searches by federal health

⁶ Statements by British obstetricians in the Reports of the Dublin maternity hospitals confirm that the operation was occasionally performed in Britain in the late 1940s, but it is impossible to determine the extent of its use without hand-searches of archival material, where it survives.

⁷ Donald A.M. Gebbie, 'Vacuum Extraction and Symphysiotomy' in the *British Medical Journal* (February 4, 1967), Vol. 1, p. 301.

⁸ *Statistics of the Royal College of Obstetricians and Gynaecologists*, on labour and delivery, and maternal and perinatal mortality.

⁹ Wykes, C.B., Johnston, T.A., Paterson-Brown, S. and Johanson, R.B. 2003. 'Symphysiotomy: a lifesaving procedure' in *British Journal of Obstetrics and Gynaecology: An International Journal of Obstetrics & Gynaecology*, No. 110, pp. 219–221.

¹⁰ E.L. García-Triviño, 'La sinfisiotomía y su posición en la actual obstetricia', *Acta Ginecol* 1955, Vol. 6, pp. 143–149, cited in Kenneth Bjorklund, 'Minimally invasive surgery for obstructed labour: a review of symphysiotomy during the twentieth century (including 5000 cases)' in *British Journal of Obstetrics and Gynaecology*, March 2002, Vol. 109, pp. 236–248.

¹¹ S. Dexus & N. Salarich, 'Supplementary symphysiotomy of recourse and in emergencies in fetal extraction by natural route' (De la sinfisiotomía complementaria de recurso o de emergencia en el curso de la extracción fetal por las vías naturales) in *Rev Esp Obstet Ginecol* 1954;13:358–366, cited in Bjorklund.

staff in Germany also failed to establish rates.¹² Although international comparative statistics relating to maternal and infant mortality and morbidity are available from 1960 through the Organisation for Economic Co-Operation and Development Statistical Extracts, there are no figures for symphysiotomy.¹³ The key databases for France, including those of the Institut National d'Etudes Démographiques (INED) and the National Institute of Statistics and Economic Studies (INSEE) were searched, and although some historic data on maternity care is available, there is no mention of symphysiotomy. The procedure was used in France, but the available material relates primarily to the first half of the twentieth century.¹⁴ Thus symphysiotomy does not appear in the accessible data for western Europe, despite its limited use in Spain, nor does it feature in European medical research literature, despite its occasional use in mid-century.¹⁵

There is a good deal of discussion as to the potential role of symphysiotomy in reducing the rising caesarean section rate in the developed world. One obstetrician has used a small number of symphysiotomies (6) in Canada to deal with emergency deliveries in which caesarean was refused, or inappropriate, and his interventions are provoking a reappraisal, and discussion of, a possible reintroduction of the procedure in Western obstetrics.¹⁶

Rates in Ireland:

Despite the use of symphysiotomy in several Irish hospitals, it does not feature in the historic vital statistics published by the Central Statistics Office, and there is no relevant data at the Economic and Social Research Institute (ERSI). Symphysiotomy pre-dates the modern Hospital Inpatient Examination (HIPE) database, and checks by staff in all of the maternity hospitals reveal no figures on the procedure since its commencement. Annual reports and maternity registers were collated for certain

¹² In common with most European states, Germany is retrospectively compiling health data. However, the searchable material is too recent for this study. Staff conducted searches of historic health data and found no results.

¹³ OECD Statistics datasets on maternal and infant mortality, and morbidity, 1960-2010.

¹⁴ M. Dumont, 'The Long and Difficult Birth of Symphysiotomy, or, From Severin Pineau to Jean-Rene Sigault' in *Journal de Gynécologie, Obstétrique et Biologie de la Reproduction* (Paris) 1989; No. 18, Vol 1, pp. 11-21.

¹⁵ Establishing accurate figures for usage in western Europe will require hand-searches of individual maternity hospital registers.

¹⁶ S. Menticoglou, 'Is there a Role for Symphysiotomy in Developed Countries?' in *Journal of Obstetrics and Gynaecology*, May 2009, Vol. 29, No. 4, pp. 272-277

hospitals over this time period and these, where available, provide the data on rates for this draft report. Although the Dublin maternity hospitals and Our Lady of Lourdes Hospital provide figures for the procedure in their published annual reports, the other hospitals do not, and securing precise detail on the procedure will require hand searches of maternity patient medical charts: this requires patient permission, and is outside the terms of reference of this draft report, which is to look at published reports. The survival rates of primary maternity records in individual hospitals varies widely. In some hospitals, only birth registers survive, in others, there are complete patient medical charts.

The compilation of rates from the Irish public maternity hospitals has been complicated by the merger of several hospitals in recent years. This has resulted in original records being placed in storage, access to which is dependent upon patient permission. The use of the procedure varied considerably across the country, with the largest numbers in Dublin, Drogheda and Cork:

Letterkenny General Hospital: Search of records confirmed no symphysiotomies.

Sligo General Hospital: Search of records confirmed no symphysiotomies.

Portlincula Hospital, Ballinasloe: Fewer than 5 confirmed symphysiotomies.

Galway University Hospital: Search of records confirmed no symphysiotomies.

Mid-Western Regional Maternity Hospital, Limerick: Fewer than 5 confirmed symphysiotomies.

Midland Regional Hospital, Mullingar: Search of records confirmed no symphysiotomies.

Midland Regional Hospital, Portlaoise: Search of records confirmed no symphysiotomies.

Waterford Regional Hospital (Airmount Hospital): Fewer than 5 symphysiotomies (to be confirmed).

Rotunda Hospital Dublin: 24 confirmed symphysiotomies.

National Maternity Hospital Dublin: 281 symphysiotomies (to be confirmed; likely to be slightly higher).

Coombe Hospital Dublin: 242 symphysiotomies (to be confirmed).

Our Lady of Lourdes Hospital: 378 confirmed symphysiotomies.¹⁷

Louth County Hospital: search of records confirmed no symphysiotomies.

Cork University Maternity Hospital (created from the merger of the Bon Secours, St Finbarr's and Erinville Maternity Hospitals): 51 confirmed symphysiotomies.¹⁸

Terms of Reference:

The following are the Terms of Reference agreed with the Department of Health for this Report:

Document the rates of symphysiotomy and maternal mortality in Ireland from 1940 to date by reference to available data (including annual reports and other reports)

- Assess symphysiotomy rates against maternal mortality rates over the period
- Critically appraise international reviews of symphysiotomy practice and associated rates in a number of comparable countries in the world and in Ireland
- Review any guidelines and protocols that applied in Ireland on symphysiotomy over the time period
- Write a report based on the findings of the above analysis providing an accurate picture of the extent of use of symphysiotomy in Ireland, and an examination of the Irish experience relative to other countries.

Assess symphysiotomy rates against maternal mortality rates over the period:

See pp. 19-23; 30-32; 37, and *passim*.

¹⁷ For the period 1944-1984. The returns in the table for Our Lady of Lourdes Hospital on p. 48 are based on the published reports, which cover the period 1958-1984.

¹⁸¹⁸ The second consultation phase suggests that these figures are slightly higher, but it is beyond the Terms of Reference to conduct hand searches of historic maternity records to confirm this.

Critically appraise international reviews of symphysiotomy practice and associated rates in a number of comparable countries in the world and in Ireland:

European reviews of symphysiotomy relate principally to the early twentieth century, when the procedure was little used in Ireland. When symphysiotomy was most extensively used in Ireland, in the 1950s, it was rare in Europe, and in the developing world. It began to be employed in the developing world more extensively from the late 1960s and the 1970s onwards. Thus Ireland has a unique usage profile, with the procedure at its peak in the 1950s when it was no longer used in western Europe, but before it became a more common procedure in the developing world in the 1960s and '70s. The critical appraisal of the procedure in this report is based upon three bodies of work: 1. Medical evaluations of the procedure from early twentieth-century Europe. 2. Assessments of the usage and outcomes in mid-twentieth century Ireland, in the specific context of Irish medical, religious, legal and social circumstances. 3. The most recent medical literature on the procedure, which comes for the most part from experiences in the developing world, where caesarean sections are often not available or are rejected by patients.

A Cochrane Review of symphysiotomy was published in 2010.¹⁹ It noted that there has never been a randomised trial of symphysiotomy, and that results from the procedure are based upon a substantial body of observational evidence. It concluded that the procedure has a potentially life-saving role to play in the developing world, and with proper training and aftercare, offers a clinically acceptable response to obstructed labour in environments where caesarean section is unavailable or unacceptable. The high mortality and morbidity rate associated with childbirth in the developing world, where over 530,000 women die in childbirth each year, an estimated 50,000 because of obstructed labour, has intensified the discussion over the potential of the procedure. The result of the second consultative phase of this Report suggests that there might be a good deal of value in conducting

¹⁹ 'Cochrane Reviews are systematic reviews of primary research in human health care and health policy, and are internationally recognised as the highest standard in evidence-based health care. They investigate the effects of interventions for prevention, treatment and rehabilitation.' J.G. Hofmeyr & M.P. Shweni, 'Symphysiotomy for feto-pelvic disproportion (Review)' in *The Cochrane Library* 2010, Issue 10, p. 2.

a study based upon Irish patients, to understand its long-term impacts, and inform practice elsewhere.

Review any guidelines and protocols that applied in Ireland on symphysiotomy over the time period:

There were no guidelines or protocols in Ireland on symphysiotomy in the mid-twentieth century (see p. 24 onwards).

Additional Objectives, added by the author:

The practice of symphysiotomy is controversial. Throughout the twentieth century, it was a procedure that provoked intense discussion in the medical profession, and the reluctance of many obstetricians to employ it in delivery stemmed from anxiety regarding the long-term effects of interference with the mother's skeletal structure. As medical interventions became more sophisticated in the mid-twentieth century, and maternal and foetal outcomes improved, symphysiotomy declined. Suspicions were therefore raised as to why the procedure was used in Ireland when it had largely disappeared from other European countries. Although the Department of Health commissioned a report within the terms of reference above, this author increasingly felt that it needed to address the survivors' central question: why was symphysiotomy used in Ireland? Moreover, why was it used in their particular cases? The second question cannot be answered without an examination of individual case notes, which is not possible in terms of a general report, but the author felt it imperative to engage with the use of the procedure in Ireland within its highly specific social, religious, and political circumstances. Thus two additional objectives arise. The first is to assess, on the basis of medical practice from the 1940s to the 1980s, the suitability of the procedure in Ireland. It is not the purpose of this report to evaluate symphysiotomy as a medical procedure *per se*. As will be seen, there is an international unanimity of opinion amongst obstetricians and midwives as to the value, and indeed the life-saving potential of symphysiotomy in specific clinical situations.²⁰ This opinion is offered in environments with high levels of infant and

²⁰ The practice has come under particular scrutiny in the last decade, for two principal reasons. The first is the appalling rate of maternal mortality in the developing world, despite a series of targets for

maternal mortality²¹ and morbidity²², where caesarean sections may not be safe or indeed even available, and where cases of neglected labour are relatively common. These incidents arise most commonly in the developing world, and it is therefore from those regions, and especially Africa, that the widest range of research has come in recent years. This has had the effect of consolidating a suspicion amongst observers that symphysiotomy is an inferior procedure, and has made an impartial evaluation difficult. Few western practitioners have personal experience of its application, or its effects. Symphysiotomy is included in the *Managing Obstetric Emergencies and Trauma – the MOET Course Manual*,²³ a core training text in British obstetrics, and there is agreement regarding the necessity for its inclusion in the training of European obstetricians and midwives for those emergencies where its use is indicated. However, the application of symphysiotomy in the developed world is rare, as caesarean section is routinely used before extreme difficulties arise: ‘Not only are the indications for symphysiotomy rare in developed countries, but the cases that might benefit from symphysiotomy – mainly obstructed after-coming-head and failed instrumental delivery in a woman unfit for an urgent CS – are such dire

reduction. Over half a million women die in childbirth annually, and it is estimated that between 8 and 10% are as a result of obstructed labour, a major indication for symphysiotomy. The second is a growing concern regarding the rise in Caesarean Section in the western world, standing at over 30% of all births in the United States, 26% in Ireland, and almost 25% in Britain. Symphysiotomy is now being discussed in western medicine in the context of reducing the CS rate, especially in North America. See E. Declercq, F. Menacker & M. MacDorman, ‘Maternal risk profiles and the primary caesarean rate in the United States, 1991-2002’ in *American Journal of Public Health* 2006b, Vol. 96, pp. 867-72; C. McCourt, J. Weaver, H. Statham, S. Beake, J. Gamble & D. K. Creedy, ‘Elective caesarean section and decision making: A critical review of the literature’ in *Birth* 2007, vol. 34, pp.65-79; *Healthy Baby Directory for the West of Ireland*, Association for the Improvement of Maternity Services in Ireland, 2011; J.P. Rooks, N.L. Weatherby, E.K. Ernst, S. Stapleton, D. Rosen & A., Rosenfield, ‘Outcomes of care in birth centers: The National Birth Center Study’ in *New England Journal of Medicine*, 1989, Vol. 321, pp. 1804-11; F. Althabe & J.F. Belizan, ‘Caesarean section: The paradox’ in *The Lancet* 2006, Vol. 368, pp. 1472-3; K.C. Johnson & B.A. Daviss, ‘Outcomes of planned home births with certified professional midwives: Large prospective study in North America’ in *British Medical Journal* 2005, vol. 220, p. 1416; S.M. Taffel, P.J. Placek & T. Liss, ‘Trends in the United States caesarean section rate and reasons for the 1980-85 rise’ in *American Journal of Public Health* 1987, Vol. 77, pp. 955-9, U.S. Department of Health and Human Services. Maternal, infant and child health. *Healthy People 2010*, 2nd ed. Washington DC: U.S. Government Printing Office, November 2000, pp. 16-30-31, and international citations throughout this report.

²¹The number of deaths per 100,000 (or, occasionally, 10,000) live births. Maternal mortality is one of the standard measures of the quality of a health care system.

²² In this context, morbidity refers to the frequency of the appearance of complications following symphysiotomy, as opposed to the prevalence of disease.

²³ Charlotte Howell, Kate Grady and Charles Cox (eds), *Managing Obstetric Emergencies and Trauma – the MOET Course Manual* Royal College of Obstetricians and Gynaecologists, 2007, Section 4: ‘Obstetric Emergencies’.

emergencies, that it is hardly a suitable opportunity to teach the procedure or even for an obstetrician to maintain a rarely used skill.’²⁴

The second additional objective is an evaluation of whether symphysiotomy was used inappropriately in Ireland. It has been contended that the procedure was employed in cases where a caesarean section would normally have been indicated, and that as a result mothers were subject to a clinically inferior form of treatment. Moreover, there exists a suspicion that the decision to perform a symphysiotomy instead of a caesarean section was influenced by a Catholic commitment to unrestricted pregnancy and childbirth, and that the obstetrical concern regarding the dangers of repeat caesareans might lead to demands for sterilisation or contraception, both anathema to practising Catholics in the period under review. Women who underwent the procedure have emphasised the importance of understanding why it was used in their cases, and if non-medical factors influenced an obstetrician’s decision to perform symphysiotomy over caesarean section (see Section Two below). Thus it is important to determine, as far as possible from this historic distance, whether an inappropriate decision was made for religious as opposed to clinical reasons.²⁵ The Hippocratic Oath requires that a physician ‘does no harm’: an inappropriate use of a procedure for reasons other than clinical would violate this basic principle, and is therefore an integral element in this draft report.

Concerns regarding symphysiotomy and the long-term effects of the procedure emerged in 2001. Since then, there have been calls for an inquiry into the practice, originally to Micheál Martin, then Mary Harney, and finally James Reilly, the current Minister for Health. The former Ministers ruled out an inquiry, but sought to have a report on the practice commissioned. This report represents the third such attempt to evaluate the practice of symphysiotomy in twentieth-century Ireland. The first was to have been undertaken by a Swedish obstetrician, who had already conducted a comparative evaluation of the international incidence of symphysiotomy in the

²⁴Douwe Arie Anne Verkuyl, ‘Think Globally, Act Locally: the case for symphysiotomy’ in *PLoS Medicine*, March 2007, Vol. 4, Issue 3, pp. 401-406.

²⁵ The published annual reports from the Dublin maternity hospitals provide detailed summaries of symphysiotomy cases in certain years, including obstetric histories, detail on the progress of labour, and information on follow-up (when the patient returned for after-care) that gives clear indications of the circumstances under which the procedure was used. Similarly, summary case notes for caesarean section patients are also provided, allowing for a comparison of cases. See Clinical Reports of the Dublin Maternity Hospitals in *Irish Journal of Medical Science* 1940-1968.

twentieth century. Following considerable public discussion, and inaccurate and unsubstantiated allegations of partiality, the obstetrician withdrew from the process. The second proposed team of investigators (based in Northern Ireland, Scotland and England) comprised an obstetrician, a clinical psychologist, and a team of researchers at the Liverpool School of Tropical Medicine: this team also withdrew as a result of disagreements over the extent and scope of the project. It is certainly a matter of regret that neither of the original reviews proceeded. Either would have provided the data required to assess Ireland's use of symphysiotomy, and advanced the investigation by some years. The women who underwent this procedure are no longer young, and deserve the satisfaction of an investigation that seeks to establish facts, and acknowledge the anxiety and pain that they have carried for a good many years.

This topic is a difficult and often painful one, a fact underlined by the divisions between elements of the survivors' groups, which has resulted in two separate organisations representing women who experienced symphysiotomy. This is not a story of heroes and villains. It is a complex interaction of medical, socio-religious and cultural factors that makes a definitive statement as to the appropriateness of the procedure in the mid-twentieth century no easy matter. Historical distance should not be used as a means of excusing unacceptable behaviour: interventions must be evaluated on an accepted standard of good practice at the time, and if a physician knowingly imposes an inferior standard of care for ideological reasons he is guilty of poor treatment, even if motivated by mistaken good intention. Equally, however, historical context is vital to a proper evaluation of practice. Medical care advances through trial and error, and it is only in the application of new techniques, some of which will inevitably produce disappointing results, that a firm empirical basis for adoption emerges. The extensive use of x-ray to diagnose pelvic disproportion, for example, which occurs as part of the development of obstetric care in the last century, and is an integral part of the symphysiotomy story, would be regarded with great alarm by modern practitioners. But it was an application of a modern technology done with the intention of improving maternity care, and abandoned when a safer and more reliable means (ultrasound) was developed. Thus the practice of symphysiotomy must be evaluated in terms of good obstetric standards that prevailed from the 1940s to the 1980s. Medical history, including the history of

obstetrics, includes many instances of interventions that were initially heralded as major advances, and relegated once the consequences were realised. Irving Loudon recounts two extraordinary developments that attracted supporters in the United States and Britain respectively:

Maternal mortality rates were also high when maximum surgical interference in normal or potentially normal labours was encouraged or advocated. A leading American obstetrician in the 1920s, Joseph Bolivar DeLee, wrote a paper entitled 'The prophylactic forceps operation' in which he advocated that procedures for ordinary deliveries be changed to include anaesthetizing every patient in the second stage of labour, delivering the baby with forceps, and manually removing the placenta using the 'shoehorn manoeuvre'. His advice was heeded by many obstetricians and horrendous examples of iatrogenic²⁶ mortality resulted. Another example, from Britain, was the widespread use of chloroform and forceps by general practitioners in uncomplicated deliveries between 1870 and the 1940s. This was described by one observer as a tendency a 'little short of murder' and accounted for many unnecessary deaths.²⁷

Definition of Symphysiotomy:

Symphysiotomy is an operation, usually carried out under local anaesthetic, to enlarge the size of the mother's pelvis and facilitate delivery in cases of relatively minor obstruction or disproportion. Where major obstruction is present, caesarean section is the appropriate procedure. It was believed that symphysiotomy resulted in a permanent enlargement of the mother's pelvis, although modern research has questioned whether this is indeed the case.²⁸

This 'plain language' summary describes the procedure:

²⁶ The result of intervention by a physician.

²⁷ Irvine Loudon, 'Maternal Mortality in the Past and its Relevance to the Developing World Today' in *The American Journal of Clinical Nutrition* Vol 72, No. 1, July 2000, p. 2425.

²⁸ J. Van Roosmalen, 'Symphysiotomy as an alternative to caesarean section' in *International Journal of Gynaecology and Obstetrics* No. 25, 1987, pp 451-458. See the same author's 1990 article on symphysiotomy in 'Safe Motherhood: caesarean section or symphysiotomy?' in *American Journal of Obstetrics and Gynaecology* July 1990, Vol 1, Part 1, No. 163, pp. 1-4.

Symphysiotomy is an operation to enlarge the capacity of the mother's pelvis by partially cutting the fibres joining the pubic bones at the front of the pelvis. Usually, when the baby is too big to pass through the pelvis, a caesarean section is performed. If caesarean section is not available, or the mother is too ill for, or refuses, caesarean section or if there is insufficient time to perform caesarean section (for example when the baby's body has been born feet first, and the head is stuck), symphysiotomy may be performed. Local anaesthetic solution is injected to numb the area, then a small cut is made in the skin with a scalpel, and most of the fibres of the symphysis are cut. As the baby is born, the symphysis separates just enough to allow the baby through. Large observational studies have shown that symphysiotomy is extremely safe with respect to life-threatening complications, but rarely may result in pelvic instability. For this reason, and because the operation is viewed as a 'second-class' operation, it is seldom performed today. Health professionals fear censure should they perform a symphysiotomy which leads to complications. Proponents argue that many deaths of mothers and babies from obstructed labour in parts of the world without caesarean section facilities could be prevented if symphysiotomy was used.²⁹

Although symphysiotomy is most often a medical intervention, performed to facilitate delivery, it may also happen spontaneously during labour. An allied procedure which severs the pubic bone lateral to the symphysis is known as pubiotomy and is rarely used. There is reference to a similar practice in Ireland in the fifteenth century³⁰ that appears to have been used prophylactically³¹:

²⁹ G. Justus Hofmeyr and P. Mike Shweni, 'Symphysiotomy for feto-pelvic disproportion (Review)' in *The Cochrane Library* 2010, Issue 10, p. 2.

³⁰ 'The wild Irish women do break the pubic bones of the female infant, so soon as it is borne. And I have heard some wandering Irish women affirm the same to be true, and that they have ways to keep these bones from uniting. It is for certain that they be easily and soon delivered. And I have observed that many wanderers of that nation have a waddling and lamish gesture in their going.' Percival Willughby, *Observations in Midwifery* (ca. 1672)

³¹ A medicine or treatment to prevent disease.

The earliest successful symphysiotomy was performed in Paris in 1777 on a woman with dwarfism who had lost her three previous children. Although mother and child survived the operation, the mother suffered significant after-effects, including severe difficulty in walking, and urinary incontinence. The operation was utilised throughout the nineteenth century in relatively small numbers, but there was a revival of interest in the procedure at the end of the century as improved aseptic techniques greatly improved the maternal mortality and morbidity rate. The technique was modified in the 1920s by an Argentinian obstetrician named Enrique Zarate so that the symphysis fibres were partially and not completely severed: this was to reduce the chance of long-term pelvic instability, as the pelvic girdle did not divide in the manner of earlier symphysiotomies.³² Local anaesthetic now also replaced general anaesthetic for the procedure, and this is the technique that was used in Ireland in the mid-twentieth century. The operation is now associated exclusively with childbirth, but has occasionally been used on men.³³ During the Vietnam War, an American surgeon used symphysiotomy to control massive haemorrhage and facilitate reconstruction following deep tissue injury by high velocity weaponry.³⁴ It was also utilised in surgery for the removal of tumours of the pelvis,³⁵ and more recently in the treatment of urethral injuries in children.³⁶

Religion and Irish Obstetrics:

Irish obstetrical practice was heavily influenced by, and constrained within, a widely accepted religious framework. This influence was not merely ideological, but also shaped legislation in order to ensure conformity to certain religious principles. The dominance of the church in almost all areas of Irish life was also felt within medicine, and in the period of this study the pernicious influence of the Catholic Archbishop of Dublin, Charles John McQuaid, spread far beyond the capital. His interference to

³² D. Maharaj and J. Moodley, 'Symphysiotomy and Fetal Destructive Operations' in *Best Practice and Research in Clinical Obstetrics and Gynaecology*, 2002, Vol. 16, No. 1, pp. 117-131.

³³ John N. Wettlaufer & John W. Weigel, *Urology in the Vietnam War: Casualty Management and Lessons Learned* Washington: Borden Institute, 2005, chapter 7.

³⁴ Stuart M. Selikowitz, 'The Symphysiotomy Approach to High Velocity Missile Trauma' in *Annals of Surgical Oncology*, Vol 178, No. 5, pp. 616-20.

³⁵ T.M. Holder & L.F. Peltier, 'Symphysiotomy for Exposure in Resection of Pelvic Tumors' *Surgery*, 60:819, 1966.

³⁶ Basiri, A, Shadpour, P, Moradi, MR, Ahmandnia H, & Madaen, K., 'Symphysiotomy: a viable approach for delayed management of posterior urethral injuries in children' in *Journal of Urology*, Nov. 2002; No. 168, Vol. 5, pp. 2166-2169.

their detriment in the broader realm of women's general health reflected a preoccupation with largely illusory battles regarding morals, ensuring that malnourished and exhausted mothers produced children whom they could not afford to feed, clean, or clothe. McQuaid, in common with the rest of the Church hierarchy, did indeed believe that 'the issue of maternity care was a religious one.'³⁷ An unyielding belief system that would not countenance artificial contraception or sterilisation for the prevention of pregnancy also placed legal restrictions upon medical practitioners, and put them in a very different position from their European peers. Many found the position intolerable. The testimony of obstetricians, and the memoirs of other practitioners, indicate how many medics struggled to provide the care their patients needed, while constrained by a conservative medical and social structure.³⁸ It is within this context that the revival of symphysiotomy must be considered: in which multiple births were the norm, artificial contraception and sterilisation to prevent pregnancy were illegal as well as ethically unacceptable, and repeat caesarean sections carried grave dangers. A procedure that appeared to offer the possibility of safe repeat deliveries for a very specific group of mothers was therefore actively explored.

It has been repeatedly claimed that symphysiotomy was promoted by Irish obstetricians, Alexander Spain and Arthur Barry (respective Masters of the National Maternity Hospital) in particular, for religious and not clinical reasons.³⁹ The first element of this claim is partly true. Spain and Barry were both devout Catholics, serving a predominantly Catholic patient population, and they made no secret of their willing conformity to religious precepts in the treatment of patients.⁴⁰ However, they

³⁷ Amongst the several disgraceful outcomes of McQuaid's interference in family life was the loss of free maternity care and meals offered by multi and non-denominational organisations such as the St John's Ambulance Brigade to Dublin mothers. Lindsey Earner-Byrne, *Mother and Child: maternity and child welfare in Dublin, 1922-60* (Manchester: Manchester University Press, 2007), p. 107.

³⁸ For discussion of the limits on medical practice in a variety of specialisms mid-century, and the general state of the nation's health, see for example Ivor Browne, *Music and Madness* (Cork: Cork University Press, 2008); J.B. Lyons JB. *A Pride of Professors; the lives of the professors of medicine at the Royal College of Surgeons in Ireland* (Dublin: A & A Farmar, 1999); Robert Collis, *To Be a Pilgrim* (London: Secker & Warburg, 1975); James Deeny, *To cure and to care: memoirs of a chief medical officer* (Dun Laoghaire: Glendale Press, 1989); Noel Browne, *Against the Tide* (Dublin: Gill and Macmillan, 1986).

³⁹ Marie O'Connor, *Bodily Harm* (Dublin: Johnswood Press, 2011), p. 82 and *passim*.

⁴⁰ Sterilisation and caesarean hysterectomies were undertaken in the Dublin hospitals, often in response to haemorrhage after delivery. There was strong opposition to sterilisation for contraceptive purposes on the part of Catholic obstetricians such as Spain, who described such intervention, even at the request of the mother, as 'mutilation'. Alexander Spain, 'Symphysiotomy and Pubiotomy: An

operated within an environment in which considerable restrictions were placed upon medical practitioners. Whatever their personal inclinations or beliefs, doctors practising in Ireland were confined by key legislative limits in relation to family planning and advice. The Censorship of Publications Act of 1929 eliminated published material that offered information on the avoidance of pregnancy by banning any material that was deemed to 'advocate the unnatural prevention of conception or the procurement of abortion or miscarriage.' Indeed, much of the emphasis of the Act, and the evidence presented to the 'Committee on Evil Literature' that shaped its parameters, concerned birth control and the prevention of conception.⁴¹ The sale of artificial contraceptives were banned under the 1935 Criminal Law Amendment Act: any doctor offering such material, and even information on it, was liable to prosecution.⁴²

Regardless of the physical and psychological stress associated with repeated pregnancy and birth, Irish family size was exceptionally large by European standards, over twice that of England. There was moreover a unique reproductive profile: marriage rates were relatively low, but fertility rates were very high, meaning that large numbers of Irish men and women never married, but those that did had very large families: 'It is in connection with the structure of childbearing in this period, rather than overall fertility rates, that Irish exceptionalism can again be unambiguously asserted. In Ireland, the uniqueness of the structure of childbearing lay in the degree to which marriages were few but families were large, a combination which had been a feature of Irish reproductive patterns since the late nineteenth century.'⁴³ Any young woman starting a family in this period could conservatively

Apologia based on the study of 41 cases' in *Journal of Obstetrics and Gynaecology of the British Empire*, 1949, Vol. 56, pp. 576-85.

⁴¹ Although the Catholic church vigorously advanced the Act, the Church of Ireland took an active part in shaping its provision through the Anglican Committee member. For a discussion of the records relating to the Committee, see Tom Quinlan, 'Ferretting Out Evil: the records of the Committee on Evil Literature' in *Journal of the Irish Society of Archives*, Autumn 1995, Vol. 2, No. 2, pp. 49-56.

⁴² Section 17 of the Act stated: 'Any person who acts in contravention of the foregoing sub-section of this section shall be guilty of an offence under this section and shall be liable on summary conviction thereof to a fine not exceeding fifty pounds or, at the discretion of the court, to imprisonment for any term not exceeding six months or to both such fine and such imprisonment and, in any case to forfeiture of any contraceptive in respect of which such offence was committed.'

⁴³ Tony Fahy, 'Trends in Irish Fertility Rates in Comparative Perspective', in *The Economic and Social Review*, Vol. 32, No. 2, July, 2001, p. 159.

expect to bear five live children,⁴⁴ without the benefit of pauses through contraception. But this statistic provides only a partial picture of individual reproductive profiles. Ireland was unique in the post-war western world in terms of numbers of individual pregnancies, and in home deliveries. In the 1950s, medical students from the UK attended the Dublin hospitals in order to experience both the domiciliary delivery system⁴⁵, which had disappeared in Britain when hospital delivery became the norm under the National Health Service, and to treat the 'Grand Multipara': a woman who has had six or more children. Hospital records provide general detail on family size, and mothers on their eighth pregnancy were so common that they did not excite particular comment. In addition to the live births, women could furthermore expect to suffer miscarriage, stillbirth, and post-partum difficulties including incontinence, uterine prolapse, diabetes insipidus, and perineal problems.⁴⁶

Many Irish women were indeed 'slaves to fertility' in this era. Although the acceptance of strictures upon family size and family life may seem incomprehensible from the perspective of the early twenty-first century, with modern open access to contraception, the reality was that all agents operated in an environment of general acceptance of a startling level of interference in private matters. It is necessary to understand the depth and unquestioning acceptance of such strictures upon personal autonomy, and the importance of religious observance in all aspects of Irish life. It was only as recently as 1979 that the Family Planning Act was passed, and even then contraception was legally limited to married couples, and only available on prescription.⁴⁷ In the 1940s, women who had problematic deliveries were a pressing concern: where in Britain sterilisation or limited contraception⁴⁸ were options in some cases, there was no such choice in Ireland (even in Britain, contraception was legally

⁴⁴ 'In 1946 Irish couples who had been married for thirty to thirty-four years (married 1912-16) had on average 4.94 children.' Mary Daly, *The Slow Failure: population decline and independent Ireland, 1922-1973* (Wisconsin: University of Wisconsin Press, 2006), p. 122.

⁴⁵ Deliveries in the home, as opposed to hospital.

⁴⁶ Maternity hospitals spent a good deal of time addressing underlying pregnancy-associated problems in mothers, and attempting to establish a basic level of health. It was widely acknowledged that larger families contributed significantly to ill-health amongst mothers and children, as scant resources were stretched ever further, and debilitated women gave birth in turn to malnourished infants.

⁴⁷ Diarmaid Ferriter, *The Transformation of Ireland 1900-2000* (London: Profile books, 2004), p. 666.

⁴⁸ Although condoms were relatively available after 1918, it was not until 1961, and the introduction of the pill, that a reliable form of artificial contraception was taken up in the UK in large numbers. Illegal (or 'criminal') abortion was common in Britain until 1968, when abortion was legalised under the 1967 Abortion Act.

limited in the post-war years to married men and women, and only on prescription⁴⁹). It was the lack of options in the control of fertility that was one of the key factors behind a return to symphysiotomy.

This is the explicit theme of successive 'Transactions' of the Royal Academy of Medicine, the published accounts of discussions of the three Dublin maternity hospital annual reports, and the subject of several separate publications by the Dublin Masters. In the course of the discussions, the standards of obstetric care in Ireland in relation to Britain were the source of frequent comment. Symphysiotomy was regularly raised as a specific difference in practice between the two states (see comments below), and variations in other approaches were also noted. The visiting British obstetricians observed that Irish maternity care in general was more conservative, meaning that there was a policy of non-intervention as far as possible⁵⁰, and a desire to permit the mother to deliver naturally. Although Caesarean Section rates were comparable with those in Britain, mothers were permitted to labour for longer periods of time before surgery, and this attracted some comment. Over the years of this study, prolonged labour was frequently mentioned, and the respective Masters initiated a policy of earlier intervention as a result. Symphysiotomy in Ireland has been associated with younger mothers,⁵¹ and this is borne out by experience in the developing world, where symphysiotomies are

⁴⁹ 'In circulars issued by the [British] Ministry of Health the authorities have been advised that (1) they have no general power to establish birth control clinics as such; (2) advice on contraceptive methods should be given only to:

- (a) Married women who, being expectant or nursing mothers, are attending welfare centres and for whom further pregnancy would be detrimental to health; and
- (b) Married women attending clinics for women suffering from gynaecological conditions for whom pregnancy would be detrimental to health, either because of some gynaecological condition or because of some other form of sickness, physical or mental, such as tuberculosis, heart disease, diabetes, chronic nephritis, etc.'

The establishment of the NHS was regarded as key in reforming this patchy provision: 'we recommend that restrictions be removed and that the giving of advice on contraception to married persons who want it should be accepted as a duty of the national health service...Some doctors would also object, on religious or other grounds, to giving advice on contraception, but this is unlikely to be a serious impediment to national policy if patients are given the right to seek advice, if they want it, from other doctors within the National Health service.' *Royal Commission on Population Report*, (London: His Majesty's Stationary Office, June 1949), p. 194.

⁵⁰ This term includes assistance at all levels, including induction, forceps, vacuum, episiotomy, symphysiotomy and caesarean section.

⁵¹ Jacqueline K. Morrissey, *An Examination of the Relationship between the Catholic Church and the Medical Profession in Ireland in the period 1922-1992, with particular emphasis on the Impact of this Relationship in the Field of Reproductive Medicine* (Unpublished PhD thesis, University College Dublin, 2004), p. 188.

indicated in cases where very young and physically undeveloped women face problems of pelvic disproportion in greater numbers than older mothers.

Symphysiotomy was a statistically exceptional intervention in Irish obstetrics. At the height of its use in Dublin, from the mid 1940s to the mid 1950s, when it went into decline, it accounted for 0.34% of the total deliveries at the National Maternity Hospital, and 0.4% at the Coombe.⁵² The caesarean section rate increased from 1.1% to 4.6% in the same period, and remained on a steady upward trajectory.⁵³ From the outset, symphysiotomy was viewed as a means of coping with a very specific cohort, and was never proposed as an alternative to caesarean section. The circumstances under which the procedure was to be performed did not vary significantly over the course of thirty years, despite optimistic predictions by both Spain and Barry that it would find additional applications. The indications for symphysiotomy both remained generally constant over the period under review, and conformed to those recommendations outlined by recent literature, with one important exception (see ‘symphysiotomy on the way out’ below). The tables below compiled from the Dublin maternity hospital annual reports provide figures for the rise and fall in the use of symphysiotomy, and selected comments from the Masters as to the use and consequences of the procedure – see footnotes for critical evaluations of individual cases, as well as indications of use in non-emergency situations. **A note on terms:** the Dublin reports use a variety of terms to describe non-emergency symphysiotomies, including ‘on the way out’, ‘in combination with caesarean section’, ‘elective pre-labour symphysiotomy’ and ‘symphysiotomy at section’. Their use is dependent upon the specific circumstances of each delivery, and are cited in this report’s footnotes as they appeared in the original documents. Please also note that the footnoted comments on individual deliveries are a selection from a much larger number, chosen to illustrate the differing circumstances under which symphysiotomy was used. The annual reports contain much additional comment and information.

⁵² Calculated from the Annual Clinical Reports, 1945-1965 inclusive. The Rotunda has been excluded as symphysiotomy was rarely used, and its inclusion would artificially lower the overall rate.

⁵³ The national rate is now 26.2%, well above the target of 10-15% set by the World Health Organisation. *Perinatal Statistics Report* (Dublin, 2009), p. 19.

Rates of Symphysiotomy⁵⁴ and Caesarean Section in the Dublin Hospitals:⁵⁵

Rotunda Hospital:

YEAR	No. Of Symphys	Symphs as % of births	Mat Deaths Symph	Foetal Deaths Symph	No. Of CS	CS as % of births	Mat Deaths CS	Foetal Deaths CS	Total Deliveries
1948	0	0	0	0	95	1.9	4	5	4,788
1949	0	0	0	0	113	1.9	1	4	5,740
1950	0	0	0	0	131	2.3	2	13	5,509
1951	1	0.01	0	0	135	2.3	3	24	5,718
1952	7 ⁵⁶	0.16	0	0	201	3.4	1	34	5,874
1953	3 ⁵⁷	0.07	0	0	152	2.8	0	6	5,286
1954 ⁵⁸	2	0.04	0	0	166	3.8	2	16	5,623
1955	2 ⁵⁹	0.03	0	0	167	2.9	0	10	5,731
1956	1 ⁶⁰	0.01	0	0	148	2.5	0	10	5,845
1957	1	0.01	0	0	211	3.9	2	25	5,366
1958	0	0	0	0	171	3.0	0	7	5,554
1959	0	0	0	0	189	3.8	2	6	6,120

⁵⁴ These tables are for the years of highest usage of the procedure: figures showing usage for all years (checked where available against the maternity registers) will be included in the final report.

⁵⁵ The annual reports were published by the three hospitals until 1968. These tables reflect the years of highest usage of symphysiotomy in Dublin.

⁵⁶ These symphysiotomies were performed 'at Caesarean Section to facilitate vaginal delivery in future pregnancies'.

⁵⁷ These three were 'Symphysiotomy at Section'.

⁵⁸ Prof. A.S. Duncan of Cardiff noted: 'The pride of place given in the Rotunda Report to the Social Service Department emphasises to us the ever-increasing realisation of the importance of socio-economic factors in the aetiology of obstetrical abnormalities' p. 527. Commenting on the issue of possible incontinence following symphysiotomy, he stated: 'One cannot very well come to Dublin and not comment on the operation of symphysiotomy. I am impressed, and convinced of its value in the failed forceps type of case, but I must confess that I am still unhappy about the prophylactic operation or the symphysiotomy combined with Caesarean Section. The sequelae [long term ill consequences] in your experienced hands certainly seem to be minimal. There has been considerable criticism in relation to the incidence of subsequent stress incontinence of urine, but I think we must remember that stress incontinence of minor degree is very common in women, and that this becomes more clear if patients are asked specifically about the symptom. In this connection you may be interested in the results of a questionnaire study which I recently carried out amongst young nulliparous [women who have never given birth to a live infant] hospital nurses. Of 134 nurses who replied to the questionnaire, 87 or nearly two-thirds stated that they had at one time or another experienced stress incontinence. Of these, 17 had experienced it frequently, and 18 at times when the bladder was not even full. In 58 the causative stress was as simple an action as laughing. If we consider that these were young nulliparae I think that we must not criticise too strongly the minor degrees of incontinence displayed for example by some of Dr. Feeney's followed-up series.' p. 528.

⁵⁹ Combined with Caesarean Section.

⁶⁰ Combined with Caesarean Section.

1960	0	0	0	0	196	3.0	0	15	5,840
1961	1	0.01	0	0	224	4.1	2	18	5,356
1962	3 ⁶¹	0.05	0	0	243	4.3	0	26	5,648
1963	3	0.05	0 ⁶²	0	270	4.7	2	15	5,727
1964									
1965	0	0	0	0	335	5.1	2	30	6,472

Coombe Hospital:

YEAR	No. Of Symphs	Symphs as % of births	Mat Deaths Symph	Foetal Deaths Symph	No. Of CS	CS as % of births	Mat Deaths CS	Foetal Deaths CS	Total Deliveries
1950	11	0.3	0	1	31	0.9	0	2	3,548
1951	16	0.4	0	1	82	2.2	0	12	3,666
1952	19	0.4	0	3	100	2.3	1		4,301
1953	25	0.7	0	1	115	3.0	1	6	3,749
1954	19 ⁶³	0.5	0	2	116	3.0	0	9	3,860
1955	15	0.4	0	2	94	2.5	2	6	3,685
1956	32	1.0	0	4	89	2.8	1	8	3,187
1957	6	0.2	0	0	104	3.3	0	11	3,103
1958	8	0.3	0	0	134	4.6	0	10	2,883
1959	13 ⁶⁴	0.4	0	0	124	4.0	1	13	3,072
1960 ⁶⁵	17 ⁶⁶	0.5	0	1	131	3.9	0	17	3,387
1961 ⁶⁷	12 ⁶⁸	0.3	0	0	96	2.8	1	4	3,420

⁶¹ Although the babies were safely delivered, the mothers suffered injury: 'Two of the patients however, have had considerable disability from stress incontinence, and this coupled with the rather prolonged convalescence necessary following the operation make it difficult for me to accept it for use in any but occasionally selected cases where a funnel-shaped pelvis leads to obstructed labour at the plane of least pelvic dimensions.' Annual Report, p. 33

⁶² Case No. 59973 was disastrous due to extraction of the head from brim level immediately following symphysiotomy. This sequence of events (symphysiotomy immediately followed by forceps) is reported by experts on symphysiotomy to be the worst possible procedure and the one most likely to be followed by severe stress incontinence. Caesarean section should have been performed in this case, and the subsequent career of this patient has been quite disastrous.' Annual Report, p. 35

⁶³ Two were combined with Caesarean Section.

⁶⁴ Nine of these were 'prophylactic'.

⁶⁵ There were 24 vaginal deliveries after symphysiotomy this year.

⁶⁶ Four of these were prophylactic.

1962 ⁶⁹	4	0.1	0	0	135	3.8	0	6	3,522
1963 ⁷⁰	5	0.1	0	1	140	4.1	1	7	3,401
1964									
1965	0	0	0	0	170	5.5	1	15	3,106

National Maternity Hospital:

YEAR	No. Of Symphs	Symphs as % of births	Mat Deaths Symph	Foetal Deaths Symph	No. Of CS	CS as % of births	Mat Deaths CS	Foetal Deaths CS	Total Deliveries
1950	20	0.4	0	5	58	1.3	1	20	4,555
1951	18	0.4	0	2	44	1.0	3	5	4,486
1952	28	0.5	0	5	67	1.2			5,715
1953	18	0.3	0	2	58	1.2	0	7	5,392
1954	33	0.6	0	4	53	1.0	0	9	5,298
1955	33	0.6	0	0	51	0.9	0	2	5,432
1956	21	0.4	0	2	93	1.8	1	7	5,093
1957	9	0.2	0	0	87	1.8	0	2	4,717
1958	6	0.1	0	0	88	1.8	0	5	4,752
1959									
1960 ⁷¹⁷²	16	0.3	0	0	100	1.8	0	9	5,492
1961 ⁷³	12 ⁷⁴	0.2	0	1	140	2.5	2	15	5,500
1962 ⁷⁵	19 ⁷⁶	0.3	0	0	133	2.4	1	9	5,607
1963 ⁷⁷	12	0.2	0	0	168		0	6	

⁶⁷ 20 had vaginal deliveries following symphysiotomy. 'None of these women on careful questioning showed any of the disabilities so commonly attributed to this operation. None of them had any abnormality of gait or stress incontinence.' p. 40

⁶⁸ Of the 12 symphysiotomies, eight were in labour and four prophylactic

⁶⁹ 13 patients delivered vaginally following symphysiotomy.

⁷⁰ 16 patients delivered vaginally following symphysiotomy.

⁷¹ Six patients had a symphysiotomy this year as an elective procedure before the onset of labour: Five delivered vaginally, one by caesarean section because of rupture of a previous section scar.

⁷² There were 28 vaginal deliveries following previous symphysiotomy this year, 24 spontaneous, 4 with forceps.

⁷³ 22 delivered vaginally after symphysiotomy, 19 spontaneous, three with forceps.

⁷⁴ Three were elective pre-labour symphysiotomies; four were 'on the way out'.

⁷⁵ 25 delivered vaginally after a previous symphysiotomy, 19 spontaneous, five forceps, one vacuum.

⁷⁶ 10 symphysiotomies in labour, six elective pre-labour, three 'on way out'.

⁷⁷ 22 vaginal deliveries after symphysiotomy. '[There was]...no case of orthopaedic problems this year, but one of severe incontinence.'

1964									
1965	5	0.09	0	1	211	3.7	1	18	5,747

The pattern of use of symphysiotomy in the Dublin public hospitals was therefore as follows: the procedure was rarely used at the Rotunda, although the hospital was unique in employing it most often **after** caesarean section, in anticipation of the next obstructed pregnancy. This did not follow good clinical practice, in which symphysiotomy was and is regarded as appropriate only during labour (see below). Symphysiotomy was statistically a far safer procedure than caesarean section, with no maternal deaths as opposed to an average of two annually with section, and a far lower foetal mortality rate (although still a distressingly high one). The operation was most prevalent in the early to mid 1950s, when it began to decline, and was relatively rare in the 1960s. This pattern reflects the changes in maternal health and maternal care in Ireland. The health of mothers improved steadily in the late 1940s and 1950s, with a decline in women with contracted pelvis presenting for delivery. This reduced the numbers of mothers regarded as suitable cases for symphysiotomy. From the early 1950s, it also became clear that with improvements in health, and in surgical technique (especially the widespread adoption of the Lower Segment Section in caesarean section), that repeat caesarean section was safer than had previously been thought, and numbers rose accordingly. This largely eliminated the need for symphysiotomy.

Guidelines and Protocols for Symphysiotomy in Ireland:

There were no guidelines or protocols for symphysiotomy in mid-twentieth century Ireland. This was not unusual: protocols did not exist for many aspects of medical care in the twentieth century as a whole, which evolved through practical application, and were revised on the basis of discussion in professional forums such as those reported in the 'Transactions' of the Dublin Hospitals (below), in the training of students, and on the basis of published papers in medical journals. There was however a general acceptance of the indications for symphysiotomy, which were 'mild to moderate disproportion': a greater degree indicated caesarean section. When Arthur Barry proposed symphysiotomy as a response to obstructed labour, he did so on the basis of recent results reported by obstetricians in Britain and

continental Europe, including the seminal work of Chassar Moir, the British obstetrician with whom Barry was to vigorously debate in Dublin in 1951 (below).⁷⁸

In the absence of formal guidelines, the appropriate use of symphysiotomy (or indeed any obstetrical intervention) depended upon peer-review, and the audit of practice. The Inquiry of Judge Maureen Harding Clark into peripartum hysterectomy at Our Lady of Lourdes Hospital provides a valuable context for this report, in suggesting a model for investigation (albeit on a much more limited scale), as well as analysis of the influence of religious belief on medical practice.⁷⁹ It has an especial significance with regard to the use of symphysiotomy at Lourdes, and the role of audit in ensuring patient safety and maintaining clinical standards. Harding Clark found that the major factors in permitting the extraordinarily high levels of caesarean hysterectomies at Lourdes were an atmosphere in which the actions of obstetricians were accepted unquestioningly by other staff, and ‘the prevailing insular atmosphere of the unit which never questioned, reviewed or audited outcomes, [and] allowed hysterectomies for perceived haemorrhage to continue at unacceptable rates throughout the last 10 years of Dr. Neary’s practice.’⁸⁰ Another problem lay in the lack of training in modern obstetric approaches at Lourdes, and a lack of awareness regarding up-to-date approaches to problems such as post-operative haemorrhage in caesarean section. However, the situation with regard to symphysiotomy is somewhat different. In the period under review, there were no clinical guidelines for symphysiotomy. This was a period of transition in obstetric care, when maternal mortality was in decline, hospital deliveries were increasing, and medical intervention in delivery more frequent. Good practice was in a process of evolution, and the role of the published reports, and discussion of practice between hospitals, as well as by invited observers, was crucial in shaping the delivery of maternity care.

⁷⁸ In Barry’s 1952 article ‘Symphysiotomy or Pubiotomy: Why? When? And How’, he depends heavily upon Moir and Kerr’s 1949 work *Operative Obstetrics*, which indicated the appropriate use of symphysiotomy. Moir’s disagreement with Barry was less the question of symphysiotomy’s usefulness, and more the extent to which it was utilised in Dublin in comparison with the UK. Moir argued for the use of contraception and caesarean section to regulate fertility, and criticised the religious ideology that led to continual pregnancy. Barry also cited research published in Spanish (Zarate [1931]; Vautrin [1947]; Bazan and Rossi Escala [1948]; Salarich Tarrents [1949]).

⁷⁹ Judge Maureen Harding Clark, S.C., *The Lourdes Hospital Inquiry: An Inquiry into Peripartum Hysterectomy at Our Lady of Lourdes Hospital, Drogheda*. (Dublin: The Stationary Office, January 2006).

⁸⁰ *Lourdes Hospital Inquiry*, p. 249.

Audit is an integral element in the maintenance of clinical standards, and an essential safeguard against malpractice.⁸¹ In Ireland, in common with Britain in the period under review, there was no formal system of audit of practice for obstetricians. The Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland was founded in 1976, and acts as an advisory body for professional training and practice. It does not have any formal power of audit or independent investigation into obstetric practice. Prior to its establishment, the Royal College of Obstetricians and Gynaecologists in London fulfilled this role, and most senior obstetricians in Ireland held Membership of the Royal College (MRCOG), although this was not a prerequisite for practice. Membership was (and is) through examination, and implies a high standard of expertise, as it is a postgraduate qualification.⁸² Many Irish obstetricians attended training courses at the RCOG, and the Royal College played a key role in approving Irish maternity hospitals as training centres for Irish doctors. Representatives from the RCOG visited Irish maternity hospitals and inspected facilities throughout the twentieth century; they then made recommendations for improvement if necessary. Although both bodies received annual reports from some of the Irish maternity hospitals from the 1940s, there is no consistency in submission, and no obligation on individual centres to submit reports, apart from the three Dublin public maternity hospitals. When the reports were sent to the two institutions, there was no requirement to review them, compare practice between hospitals, or note areas of concern.⁸³ Thus although Irish obstetrics was overseen by two professional bodies, there was no regulatory input from them, and interventions in hospital practice occurred only for the purpose of evaluating facilities for training.⁸⁴ However, there was an annual review of practice at the Dublin Hospitals that constituted a process of audit.

Indeed, the relationship between the RCOG and Irish obstetricians is best seen in the Dublin maternity hospitals. In the period under review there was regular contact

81 Richard A. Greene of the National Perinatal Epidemiology Centre in Cork has identified the necessity for audit in obstetric care, and the difficulties associated with gathering the information necessary to identify trends. Perinatal Epidemiology Centre, Annual Report 2007, p. 4.

82 The process is a two-part examination, with the second element part of the RCOG's 'advanced training'. It is a lengthy and rigorous process. See *Royal College of Obstetricians and Gynaecologists Tips for Trainees in Obstetrics and Gynaecology*, February 2009.

⁸³ Harding Clark identified this lack of a requirement to review as a significant failing in relation to standards at Drogheda. *passim*

⁸⁴ The system of inspection is detailed in Harding Clark, *Inquiry*.

between Dublin and London, with British obstetricians travelling annually to Ireland to review and discuss developments in Irish maternity care. There were three public maternity hospitals in Dublin: the Rotunda, the Coombe, and the National Maternity Hospital at Holles Street. They are unique in operating under a system of Mastership, first established at the Rotunda Hospital in the 1750s. The Master is responsible for all aspects of care in the institution, and has been described as a chief executive as much as a clinician. The seven-year term appointments both carry a high responsibility, and offer an exceptional degree of authority. The Masters traditionally shaped the delivery of care, and in an earlier period exercised an unparalleled control over their hospitals. Practice therefore reflected the ethos of the Master, and at the National Maternity Hospital in particular in the 1940s and '50s this meant conformity to Catholic beliefs.⁸⁵ Thus there was no use of sterilisation for contraceptive purposes, and no advice on artificial methods of contraception.⁸⁶ This system prevailed for many years. Even in a period when the cultural context had altered and the general population accepted artificial contraception, some few staff at the Coombe were still reluctant to prescribe it themselves: however, they raised no objections to colleagues doing so.⁸⁷

The three hospitals published annual reports, which provided detailed information on maternity care. Although based on the reports published by the RCOG, and using clinical standards set in Britain,⁸⁸ the Irish reports were far more discursive and detailed, going beyond the largely statistical model prevailing in the UK. The reports were originally initiated in fact as a process of audit: 'Medical Audit, initiated by Master George Johnston in 1869, remained active through the debates on the annual Clinical Reports of the Dublin maternity hospitals at the Royal Academy of

⁸⁵ It would not be accurate to describe the Rotunda as a 'Protestant' hospital, although it was perceived to be largely independent of Catholic influence in the mid twentieth century. For the most part, it followed the prevailing medical ethos in not offering contraceptive advice.

⁸⁶ Both the Coombe and Holles Street began family planning clinics in the late 1950s, but offered advice only on natural methods of avoiding pregnancy.

⁸⁷ 'I had no compunctions about prescribing the pill and one of my functions was prescribing it for patients who came to me specifically for this purpose. I cannot recall that my aberrant intervention in this matter caused any concern to my obstetrical colleagues. They never spoke to me about the matter, nor did the master ever intervene despite his and his colleagues' reluctance to prescribe the pill.' Risteárd Mulcahy, *Memoirs of a Medical Maverick* Dublin: Liberties Press, 2010, pp. 102-3.

⁸⁸ The reports applied the so-called RCOG standard as a measure for Irish results in areas such as maternal and foetal mortality. The Rotunda also produced statistics under the 'Rotunda Standard' which differed from the RCOG standard, and was based upon the specific conditions prevailing in Dublin – the respective Rotunda Masters believed that this gave a more accurate picture of Irish obstetrics.

Medicine in Ireland, as maternal mortality declined through the late 1940s and 1950s.⁸⁹ The reports were published to 1968, providing a unique insight into changing obstetric practice in Ireland.⁹⁰ From the early 1940s until the practice largely ceased in the 1960s⁹¹, symphysiotomy was extensively discussed, both by the British obstetricians who were invited to review the annual reports, and by the Masters of the hospitals, and clinicians who attended the meetings. In sharp contrast to the situation uncovered by the Harding Clark Inquiry into the Lourdes Hospital, where obstetric practice was not assessed or overseen,⁹² symphysiotomy was exhaustively debated, and a wide variety of opinion expressed as to its suitability and efficacy. Thus the use of symphysiotomy in mid twentieth-century Ireland was a widely discussed approach, robustly attacked and defended over the course of twenty years.

The earliest discussions, and amongst the most intense, occurred in the early 1950s when the procedure was reintroduced. The 'Transactions' for 1951 are particularly important, as that year saw a detailed debate regarding the potential as well as limitations of the operation, and a discussion of the conservative obstetrical environment in Dublin, explicitly linked to religious belief. Obstetricians quoted biblical text at each other, and a robust attack and defence took pace, involving comments from a large number of physicians. It is clear that at this stage the potential of the operation was still being explored, especially in relation to 'curing' disproportion. This was a pressing problem in international obstetrics, known to cause problems at delivery, but very difficult to diagnose with any certainty. Prof. C. Scott Russell of Sheffield noted that 'In the Industrial North of England where I have worked for nearly five years, contraction of the pelvis is still quite common, and from my experience I can say without hesitation that the clinical methods of assessing disproportion, especially in the ante-natal period, are not precise enough in doubtful

⁸⁹ Alan Browne, 'Mastership in Action at the Rotunda, 1945-95' in Alan Browne (ed) *Masters, Midwives and Ladies-in-Waiting: the Rotunda Hospital, 1745-1995* Dublin: A & A Farmar, 1995, p. 24.

⁹⁰ There was no obligation on the part of maternity hospitals outside of the three Dublin Lying-in institutions to compile reports. They were merely required to present statistics to the RCOG in the first instance, and after 1976 to the IOG. These bodies were not required to review or respond to the reports.

⁹¹ With the exception of Our Lady of Lourdes in Drogheda, where the practice continued, albeit in diminishing numbers, until 1984.

⁹² The culture of deference to senior medical staff, and an unwillingness to question practice, allowed the anomalous situation to continue at Lourdes. Harding Clark, *passim*.

and difficult cases.⁹³ He then discussed at length the differing approaches to cope with disproportion, from methods of diagnoses (radiological pelvimetry and cephalometry; early induction of labour before the baby reaches full size; trial labour, caesarean section, and symphysiotomy: ‘Though I have performed it two or three times with benefit, I have in recent years preferred the lower segment Caesarean section’) through to results, which were mixed. Prof. Chassar Moir spoke next, and focused specifically on the imperative for vaginal deliveries in Dublin, which he viewed with some anxiety. From his perspective, it was unethical to approach obstetrics with the intention of securing limitless pregnancies and deliveries, simply because of religious belief. The debate was less about the virtues or otherwise of symphysiotomy (‘Let me make my position quite clear. I believe there is a place for symphysiotomy. I myself have used this operation in the past and am prepared to use it again in the future.’), and more about an obstetrician’s role in protecting the health of mothers and children, regardless of religious belief. Indeed, the discussion produced a general unanimity regarding the positive potential of symphysiotomy in cases of disproportion, but disagreement over what the visiting obstetricians saw as a reckless commitment to successive pregnancies at all costs. There was an explicitly expressed fear that Ireland’s prohibition of contraception and sterilisation to limit family size would result in the operation being inappropriately used.

In the ‘Transactions’ in each subsequent year, symphysiotomy was specifically discussed, until the numbers undertaken fell naturally in the late 1950s. Indeed, it is the most extensively evaluated procedure in the professional debates, and also features in each of the individual hospital reports, with summary case studies, outcomes (immediate and long-term), and detail on deliveries subsequent to symphysiotomy. Despite the optimism expressed by Barry and Spain in particular, the procedure never superseded caesarean section, which became more common with each successive year. The role of the Transactions is vital in shaping obstetric practice: it provided a forum not merely for discussion, and placed Irish practice under external observation, but in the presentation of statistics and case studies of procedures, it provided an empirical base from which evaluation could take place, and that is where its real value lay. The recognition that LSS caesareans were safer

⁹³ p. 1023.

than originally thought, and that the circumstances of mothers had improved steadily, came about because of the availability of hard data from the hospitals.

It has been alleged that symphysiotomy was chosen over caesarean section in Ireland not for clinical but ideological reasons, and that CS was a safe procedure from the 1940s. This was not the case. Ireland had a good record of successful caesarean section delivery, although a higher maternal mortality rate than that in Britain.⁹⁴ From the mid 1940s, almost all sections were the Lower Uterine Segment Section (LSS), a much safer operation than the so-called 'Classical Section' that involved a midline longitudinal incision providing a larger space to deliver the baby, but a higher mortality rate and greater long-term complications.⁹⁵ But even the LSS carried significant immediate as well as long-term health risks, which increased with repeat sections.⁹⁶ In 1948, J. K. Feeney, Master of the Coombe Hospital, published a review of Caesarean Sections in Dublin in 1946, indicating that poor maternal health, combined with multiple repeat sections as a result of high fertility, led to a substantially increased mortality rate:

One of the aims of the conscientious obstetrician is to keep his Caesarian section rate as low as is compatible with intelligent and conservative obstetrical practice. Whilst a very low rate is not necessarily an indication of obstetrics of a high standard, it should be constantly borne in mind that a Caesarian section is a major abdominal operation accompanied by maternal mortality and morbidity rates which are considerably higher than those of vaginal delivery. It has been estimated that Caesarian section performed under ideal conditions should carry with it a maternal mortality rate of only 0.5% to 1%, but this figure has not yet been attained in the mass

⁹⁴ Maternal mortality following caesarean section was between 0.5-1.1% nationally in Britain, and 2% in Ireland.

⁹⁵ The classical section was occasionally used in Dublin in specific emergency deliveries, including nuchal cord (where the umbilical cord is around the baby's neck), but was rare in the late 1950s and '60s.

⁹⁶ One of the major complications of caesarean section was 'adhesions': fibrous bands of scar tissue that form between internal organs and tissues, joining them together abnormally. They form commonly after surgery, especially abdominal surgery, as a normal part of the healing process. Repeat caesareans created a risk of large numbers of adhesions, which caused major problems in recovery, and left many patients in a great deal of pain. The Rotunda noted cases throughout the 1950s where difficulties in closing the abdominal wound after caesarean delivery occurred because of the number of adhesions.

obstetrics of hospital practice. Until all pregnant women receive the full advantages of efficient antenatal care and social service, patients suffering from serious disease and in poor condition will continue to be admitted to our maternity hospitals. In addition to the risks of operation, the remote chronic obstetrical invalidity associated with repeat Caesarian sections is an important consideration in a community in which birth control and sterilisation are not practiced.⁹⁷

In fact, the combined maternal mortality rate in Dublin following section was 2%, a figure that exceeded the prevailing rate in Britain. This varied from year to year, and between hospitals, from a high of 4.2% in the Rotunda in 1947-48 (an unusually high number, caused by women with heart disease), to 0 in 1962.⁹⁸ It was Irish women's larger family size that contributed to this higher rate, with greater numbers of pregnancies and deliveries resulting in a concomitant raised mortality and morbidity rate. But it was the babies that bore the brunt of mortality and morbidity in Ireland: 'Foetal loss is of course higher in this city (Dublin) than in London, but the circumstances are so different. Foetal loss is improving steadily every year under the influence of the maternity hospitals, but childbirth being what it is the loss in a community having four or more children per family must of necessity be greater than in communities having one and a half to two children per family...The risks to mother and child increase with increasing parity.'⁹⁹ Foetal loss was generally higher in Ireland than in Britain, at an average of 7% of all deliveries, compared with just over 4% nationally in the UK.¹⁰⁰ The difference was claimed to lie in emergency, unbooked cases in Ireland: the adjusted rate for booked cases was 4.6%.¹⁰¹

Alternatives to Symphysiotomy or Caesarean Section for Disproportion:

There were few safe alternatives until the mid 1950s. The Rotunda deviated from the NMH and the Coombe in avoiding symphysiotomy in the late 1940s, and successive

⁹⁷ J.K. Feeney, 'Caesarean Section in Dublin' in *Irish Journal of Medical Science*, Sixth Series, No. 276, December 1948, p. 777.

⁹⁸ The adjusted annual average in the 1940s and 1950s at the Rotunda was 2 deaths following section each year.

⁹⁹ A.P. Barry, 'Transactions', *Irish Journal of Medical Science* 1955, p. 531.

¹⁰⁰ 'Transactions', *Irish Journal of Medical Science* 1951, p. 1030.

¹⁰¹¹⁰¹ Booked cases had a better outlook for the simple reason that they represented mothers who attended the hospitals for prenatal care. Any problems could therefore be identified and treated before they reached a critical point. The unbooked cases formed the majority of the emergency admissions, often with no accompanying medical history.

Masters explored other possibilities for safe delivery. In the 1940s, the hospital had initiated a policy of early induction of labour, hoping to avoid the problem of disproportion by delivering the baby before it reached its full size and weight. Babies were induced at 37 weeks, with variable results: 'Our policy has been to induce labour to avoid excessive disproportion by puncture of the membranes rather than bougies, and to combine this with medicinal induction unless there appears to be established disproportion, but we do not attempt induction before the 37th week. If moderate disproportion is already present we prefer to allow trial labour at term, and, if in doubt of the final outcome, to perform Caesarean section.'¹⁰² There were many problems associated with the delivery of pre-term babies, and respiratory difficulties in particular were common. Moreover, it was still an unreliable means of avoiding the problems of disproportion, which often did not become clear until the second stage of labour. The personal preferences of the Masters determined delivery policy, and E.W.L. Thompson of the Rotunda explored other possibilities because of his own dislike of symphysiotomy. Section rates were higher there than the other two hospitals for this reason: 'Some of the less severe cases (of disproportion) could certainly have been treated by symphysiotomy, and probably very successfully. I cannot however, get away from my dislike for the general use of this procedure.'¹⁰³ Across the hospitals, there was a tendency to allow women to continue in labour for longer periods than in Britain, a policy that attracted critical comment in the 1940s.

Maternal Health and Symphysiotomy:

Symphysiotomy is associated with poor maternal health, for two principal reasons. The first relates to the main indication for the procedure: disproportion and/or contracted pelvis. Contracted pelvis was relatively common in nutritionally deprived mothers, who had not achieved full growth before pregnancy. It was frequently described in Britain in the pre and immediate post-war years, and was specifically associated with inner-city populations.¹⁰⁴ In Ireland, it was common amongst inner city mothers in Dublin, Belfast, Cork and Limerick, but also throughout rural areas.

¹⁰² Rotunda Hospital Report for 1948.

¹⁰³ Rotunda Hospital Report for 1957.

¹⁰⁴ 'I am personally convinced that nutritional and environmental factors are still responsible for the high incidence of the milder forms of pelvic contraction which exist in this region to-day.' Hector R. MacLennan, 'The Management of Labour in Contracted Pelvis' in the *British Medical Journal*, October 9, 1954, pp. 837-40. MacLennan was a consultant surgeon at the Royal Maternity and Women's Hospital, Glasgow.

The economic situation of many Irish families was dire: the 2009 *Commission to Inquire into Child Abuse* provides shocking detail regarding the deprivation faced by many Irish families because of poor wages and unemployment¹⁰⁵. Mothers and children felt the full impact of poor diet, with women in particular suffering from chronic illness associated with inadequate nutrition. They also presented in labour with complications that made them poor candidates for general anaesthetic (anaemic, with heart disease, tubercular), and ensured that symphysiotomy was considered a safer alternative to caesarean section in the 1940s and 1950s.

The Dublin maternity hospitals served areas of significant deprivation. The health of mothers in particular was often poor: it was common in working-class families for mothers to prioritise the health of husbands (as breadwinners) and children over themselves, leading to high degrees of malnourishment and chronic illness. This was a feature of working-class life in Britain in the same period, with a similar impact upon maternal and child health.¹⁰⁶ When added to frequent pregnancy and nursing, mothers were often physically debilitated when they arrived for delivery at hospital. Women presented with a wide range of chronic illnesses as well as poor physical condition, and this was a source of concern throughout their pregnancies, and had major implications for delivery and for the early health of their children. They were dangerously anaemic (in 1950, 75% of expectant mothers attending the Coombe were anaemic¹⁰⁷), malnourished, and presented with a number of life-threatening illnesses that made pregnancy a dangerous process. Rates of rheumatic heart disease and pulmonary tuberculosis were high¹⁰⁸, and it became necessary to

¹⁰⁵ David Gwynn Morgan, *Commission to Inquire into Child Abuse*, Chapter 3, 'Society and the Schools', part 1, 'Social, economic and family background: Child Poverty in Independent Ireland' 3.01-3.18, May, 2009.

¹⁰⁶ A seminal study of the impact of poverty on child health was conducted by Maud Pember Reeves of the Fabian Society in Lambeth, a working-class district of London in 1913. The study found conditions of deprivation identical to those prevailing in areas of inner-city Dublin almost thirty years later, with large family size, poor nutrition, and a heavy infant mortality rate linked to malnutrition and disease (there was a new-born mortality rate in Lambeth of 9%, but a total death rate amongst the children of the study families of a staggering 29%). *Round About a Pound a Week* (London: The Fabian Society, 1913).

¹⁰⁷ 'During the year, 30 per cent of our obstetrical patients had a haemoglobin content of less than 50 per cent, whilst 75 per cent of them had less than 70 per cent Hb. These women are ill-fitted to withstand the stress and strain of pregnancy and labour, they cannot afford blood loss and their resistance to infection is poor. Malnutrition is the most important single aetiological factor. This state of ill health occurs as a result of poverty; the diet of bread and tea; lack of cooking facilities; anorexia, nausea and vomiting and focal sepsis.' Coombe Hospital Report for 1950, p. 703.

¹⁰⁸ In the early 1950s Dr Risteárd Mulcahy was invited by Dr Feeney, Master of the Coombe, to establish a weekly clinic to treat mothers with heart disease: 'Rheumatic heart disease was still a particular scourge among the poorer classes in Ireland and particularly in women....The social

establish anaemia clinics for expectant mothers in the 1950s. Each of the hospitals also had an Almoners Department, whose purpose was to interview patients in order to determine their ability or otherwise to pay for medical treatment. The almoners however found themselves in the position of proto-social workers, finding that the economic, social and health problems faced by Dublin mothers required direct emergency relief. In the early years, the principal problem was malnutrition, and of the average 3,000 women assisted each year across the three hospitals, over two thirds required extra nutrition.¹⁰⁹ A major problem in addressing the issue was the fact that mothers, if given additional food to take home, invariably gave it to their children and spouses, and continued in the same state of ill-health.¹¹⁰ **This is not to imply that present survivors of symphysiotomy were malnourished, or from deprived backgrounds. Rather it describes the broad social and economic environment in which symphysiotomy was revived in Dublin, and the problems faced by mothers and obstetricians alike. Please see clarification of Draft Report below.**

Malnourishment caused specific obstetric problems, seen in Dublin in unusually high numbers. Placenta previa, a condition in which the placenta attaches in the lower part of the uterus rather than the more muscular upper section, occurs commonly in normal pregnancies but usually corrects itself before delivery. In about 10% of cases the placenta covers the cervix and a caesarean section is required, often relatively early to avoid the risk of haemorrhage. The condition is more frequent in malnourished women, those with a history of multiple births, and in mothers with uterine scarring from caesarean section or routine pregnancy. It can cause anaemia in mother and child, and is an indication for early, often caesarean, delivery. There were rarely fewer than 50 full-term or near-term cases in each of the three hospitals

conditions of many of them were poor, particularly in terms of malnutrition, iron deficiency anaemia and chronic respiratory infections. These were major complicating factors in the heart patients and so often helped to precipitate heart failure. There is little doubt that when the patients received optimum medical treatment, combined later with much improved social circumstances, their prognoses were greatly improved, even without surgery.' *Medical Maverick*, p. 101.

¹⁰⁹ The hospitals were unable to help all the women in need, so had to prioritise those in the direst situations. In the Rotunda in 1957 for example it was found that '2,009 mothers needed help or advice. In the Maternity Department, many patients, more particularly attending the anaemia clinic, needed material aid in procuring extra nourishing foods over and above that which could be obtained from statutory sources. Voluntary agencies frequently gave this extra assistance, and our own Samaritan Fund was used to help until such outside aid could be procured. It was observed that numerous patients did not know what constituted a well-balanced diet, and very many had not sufficient knowledge to cook plain and essentially nourishing meals.' 'Clinical Report' 1957.

¹¹⁰ Earner-Byrne, *Mother and Child*; Almoner's Report, Coombe Hospital (1950), p. 825.

each year, and while maternal mortality with the condition was very low, it took a heavy toll on babies, with a combined average foetal loss of over a third.

Malnourishment and deprivation produced additional complicating factors, the most important of which was contracted pelvis, resulting in disproportion at delivery, and seen in large numbers in British as well as Irish maternity hospitals.¹¹¹ Prof. T.N.A. Jeffcoate noted high caesarean section rates in industrial cities in the UK, and attributed it to pelvic disproportion: 'In 5 large maternity units in Liverpool not less than 350 Caesarean sections for disproportion are performed each year. I had always imagined that the high incidence of contracted pelvis in Liverpool, and probably in Glasgow as well, was accounted for in large part by Irish immigrants living in very poor circumstances.'¹¹² Malnourishment was associated with pelvic contraction, but was also implicated in a series of additional ailments that led to problems in pregnancy and delivery in Ireland, including an increasing caesarean section rate: '...considering the prevalence of contracted pelvis amongst the poor patients of this city and the large number of abnormal cases of all kinds admitted from the city and country, the present Caesarian rate of about 3.5 indicates a reasonably conservative outlook, as compared to other centres.'¹¹³

The Dublin hospitals faced additional difficulties with regard to some of their patients. Until the 1960s, it was common for women to only present for a hospital delivery once complications set in. This meant that throughout the 1940s and 1950s, one-third of the cases were 'unbooked', and presented in varying stages of difficulty. The National Maternity Hospital as a result dealt with 'a very high percentage of abnormalities' each year that could not be identified or treated in advance, increasing the likelihood of interventions such as symphysiotomy and caesarean section. This was confirmed across the Dublin hospitals, which dealt with not only unbooked cases, but emergency admissions from rural areas, amounting to 30% of their cases each year: 'Our maternal and foetal mortality is influenced by this circumstance and

¹¹¹ Pelvic Disproportion was the major indication for both symphysiotomy and caesarean section in the mid-twentieth century. As general maternal health improved, the numbers of cases dropped significantly, and as more accurate diagnoses of the condition occurred it was realised that it had been over-diagnosed in both Britain and Ireland.

¹¹² Prof. T.N.A. Jeffcoate, 'Disproportion' in 'Transactions of the Royal Academy of Medicine in Ireland' in *The Irish Journal of Medical Science* Report of Meeting of October 20th, 1950, p. 857.

¹¹³ J.K. Feeney, 'Caesarian Section in Dublin' in *Irish Journal of Medical Science*, Sixth Series, No. 276, December 1948, p. 757.

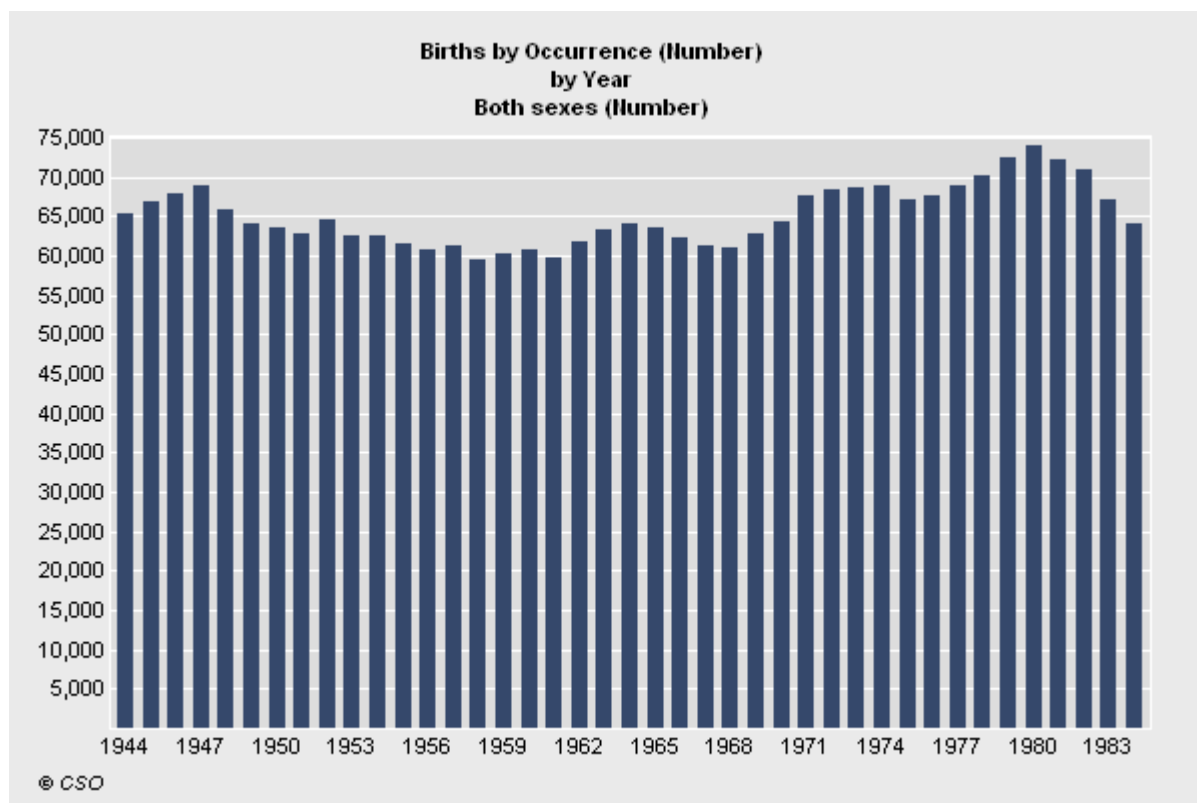
cannot be fairly compared to those institutions which deal with circumscribed geographical areas.’¹¹⁴ The rural cases were a particular problem in that many patients had already been in labour for extraordinarily long periods of time before admission to hospital: 50 hours was high in the early years, but not exceptional. Many of these patients had already undergone failed attempts at forceps delivery and other interventions, and in many cases the foetus was in distress and sometimes already dead. Thus the Dublin hospitals faced particular problems in terms of its patient profile, which made obstetric care challenging, to say the least.

In addition (or perhaps as a contributing factor to) the poor health of mothers was an exceptionally high birth rate for married women: ‘Fertility in the Republic was considerably higher than in any other western European country from the 1950s up to 2000, a period in history when control gradually became the norm. Even in the 1960s, thirty per cent of all births in the Republic were fifth births or higher. This figure had reduced to fifteen per cent by 1980, and to five per cent by 1990.’¹¹⁵ When the Advisory Body on Voluntary Health Insurance reported in 1956, it noted that premiums for maternity care would be higher than for other covers, given the high fertility rates for married Irishwomen: ‘The rate of fertility among married women in this country is high. During the period 1950-1952, the average annual number of births per 1,000 women of childbearing age was 254, compared with 111 in Britain. In the USA the figure for 1949-51 was 150, and in Denmark it was 136 for the same period.’¹¹⁶

¹¹⁴ J.K. Feeney, Coombe Hospital Report, in ‘Transactions’, *Irish Journal of Medical Science*, 1955, p. 528.

¹¹⁵ Ann Rossiter, *Ireland’s Hidden Diaspora: the ‘abortion trail’ and the making of a London-Irish underground, 1980-2000* London: IASC Publishing, 2009, p. 91.

¹¹⁶ Advisory Body on Voluntary Health Insurance Scheme Report Dublin: Government Publications, Stationary Office, 1956, p. 17.



The high birth rate, and poor health, contributed to a considerably higher than average maternal mortality rate in Ireland in comparison with other countries, although the gap closed steadily as the century advanced.

Maternal Mortality Rates¹¹⁷:

Maternal Mortality Rates in Ireland¹¹⁸, the USA, England & Wales, and the Netherlands from 1920 to 1960:¹¹⁹

	IRELAND	USA	ENG & WALES	N'LANDS
1920	62.8	68.9	43.3	24.0
1930	50.4	63.6	44.0	33.3
1940	40.2	37.6	26.1	23.5

¹¹⁷ Rate expressed as maternal deaths per 10,000 births.

¹¹⁸ Central Statistics Office, Vital Statistics, chapter 4 Infant Mortality, Stillbirths and Maternal Mortality, p. 156.

¹¹⁹ Figures for the USA, England & Wales and the Netherlands taken from Irvine S.L. Loudon, 'Childbirth' in *Companion Encyclopaedia of the History of Medicine, Volume 2* London: Routledge, 1993, p. 1067.

1950	15.5	8.3	8.7	10.5
1960	5.7	3.7	3.9	3.7

There is another important issue with regard to the prevalence of symphysiotomy in Dublin and Drogheda in particular, and its relative absence in the regional hospitals. The Dublin Masters consistently cited poor maternal health as a explanation for symphysiotomy. Their annual reports confirm that significant numbers of mothers often presented with problematic labours, and underlying, often chronic, medical conditions that made them difficult obstetrical cases. The obstetricians were both prepared for unusual cases, and were experienced in less common procedures such as symphysiotomy, making it a viable intervention. In other maternity hospitals throughout the country, however, the procedure may well have been avoided because of a lack of training and experience in its use. This factor remains a central element in discussions regarding symphysiotomy's use in the modern world: as noted earlier, even when an obstetrician is aware of the appropriate indications for symphysiotomy, there may be a reluctance to employ it because of a lack of experience.¹²⁰ Such caution seems a sensible approach to such a major medical intervention. But the role of the individual practitioner is also important. As is evident from the Dublin 'Transactions', some obstetricians had a greater faith in the procedure than others, and were instrumental in its use. This is also the case with Gerard Connolly in Our Lady of Lourdes Hospital in Drogheda, where the operation was much more extensively used than in any other regional hospital (see below). The fact that symphysiotomy largely ceased in Drogheda on Connolly's retirement underlines the association between an individual belief in the value of the procedure, and the experience to undertake it.

Context for Reintroduction of Symphysiotomy:

The procedure of symphysiotomy was reintroduced in Ireland in the mid 1940s. The principal contexts for its use were:

¹²⁰ 'Not only are the indications for symphysiotomy rare in developed countries, but the cases that might benefit from symphysiotomy – mainly obstructed after-coming-head and failed instrumental delivery in a woman unfit for an urgent CS – are such dire emergencies, that it is hardly a suitable opportunity to teach the procedure or even for an obstetrician to maintain a rarely used skill.' Douwe Arie Anne Verkuyl, 'Think Globally, Act Locally: the case for symphysiotomy' in *PLoS Medicine*, March 2007, Vol. 4, Issue 3, pp. 401-406.

- It helped to achieve a predominant goal in obstetrics of a vaginal delivery.
- It offered a means of avoiding caesarean section in cases of minor to moderate obstruction
- From the 1940s, there was a continuing rise in hospital deliveries, and a concurrent rise in major interventions including caesarean section, forceps delivery, and episiotomies
- The maternal mortality rate was much lower with symphysiotomy than caesarean section
- Advances in technology, especially x-ray, encouraged consideration of the prevalence of pelvic disproportion
- There was a growing concern regarding the rise in caesarean section, and the risks associated with multiple sections
- Sterilisation for contraceptive purposes and contraception were illegal, ensuring an exceptionally high birth rate.
- The poor health of many mothers presenting for delivery necessitated an increasingly interventionist obstetric policy

Obstetric care was utterly transformed following the Second World War. Up until the mid 1930s, maternal mortality rates had remained largely unchanged in Britain and Ireland from the 1860s. One of the most dangerous places to deliver a baby prior to 1930 was in hospital, where mothers contracted puerperal fever in huge numbers. Despite the establishment of the British College of Obstetricians and Gynaecologists in 1929 (later the Royal College of Obstetricians and Gynaecologists), and an increasing emphasis upon education and training, standards across Britain and Ireland were very varied and mortality rates high. The introduction of sulphonamide drugs¹²¹ however had a dramatic effect on survival rates, and combined with penicillin (available from 1945), significantly reduced maternal mortality. The introduction of the Irish Hospital Sweepstakes directed considerable sums of money towards the improvement of the three Dublin maternity hospitals, which received £318,483 between them from 1931-5.¹²² Thus by 1945 medical standards had risen, and a more interventionist obstetric policy developed in both countries. In Britain,

¹²¹ The first effective drug treatments against bacterial infection developed in Germany in the early 1930s.

¹²² Joseph Robins, 'Public Policy and the Maternity Services' in *Masters, Midwives and Ladies-In-Waiting: The Rotunda Hospital 1745-1995*, Dublin: A&A Farmar, 1995, p. 287.

with the creation of the National Health Service, births increasingly took place in hospital, with the domiciliary system of delivery falling rapidly out of favour.¹²³ In Ireland, the numbers of women delivering at home also decreased, but more slowly than in Britain, and the 'extern' service of the three Dublin hospitals, and to a lesser extent outside the major cities, remained a feature until the early 1970s.

Relative risks of Symphysiotomy and Caesarean Section:

One of the principal reasons for employing symphysiotomy was the dangers associated with Caesarean Section, which were very real in the 1950s and '60s. Although the operation had a high rate of success, it also had a far greater maternal mortality rate than symphysiotomy, and a higher total foetal loss rate. In the NMH in 1952 for example, 18 symphysiotomies were performed with no maternal deaths and two stillbirths, while 56 sections were undertaken, with 4 maternal deaths and 5 foetal deaths (2 stillbirths and 3 neonatal deaths).¹²⁴ The relative death rates for the two procedures remained relatively consistent. The maternal mortality rate for sections declined slowly but steadily, as the general health of mothers improved, but was always significantly higher than for symphysiotomy, where maternal deaths were very rare. It is important at this point to emphasise that in discussing relative mortality rates, it is understood that in very many cases deaths occurred not as a direct result of the procedure, whether symphysiotomy or CS, but because of an underlying health problem that was exacerbated by pregnancy and delivery. In the 1950s and '60s, section was performed under general anaesthetic, which carried a much higher degree of risk than the local anaesthetic required for symphysiotomy: this risk applied equally in other operations requiring general anaesthetic. Moreover, CS is often utilised because of a health risk to the mother in particular, meaning that even before the operation the patient is in a disadvantaged state.

The maternal health outcomes for symphysiotomy and section have been extensively studied elsewhere, and the findings broadly confirm the Irish experience:

Maternal and perinatal mortality, comparing the outcomes of symphysiotomy and caesarean section, were analysed in ten

¹²³ Martin Gorsky, 'The British National Health Service 1948-2008: A Review of the Historiography,' *Social History of Medicine*, Dec 2008, Vol. 21 Issue 3, pp 437-460

¹²⁴ Report of the National Maternity Hospital for 1952.

studies conducted between 1908 and 1995 comprising about 800 symphysiotomies and 1200 caesarean sections. Maternal mortality was four times higher with caesarean section than with symphysiotomy during the first half of the century and six times higher in the second half of the century. Perinatal mortality was the same for symphysiotomy and caesarean section.¹²⁵

Perinatal outcomes were rather better in Ireland in the later years of use. In the Dublin hospitals, perinatal deaths were on average 15% for symphysiotomy in the 1940s, dropping to 8% in the early to mid-1950s.¹²⁶ Caesarean section perinatal death rates were higher, and varied year to year, but saw a similar drop from a high of 25% to 12% in the period under review. There were of course remarkable exceptions to the accepted rules, which were specifically commented upon. One mother's spectacular reproductive career ended with a caesarean hysterectomy in 1951: 'Case 4 must present a world's record in Caesarean sections: 3 classical, 6 lower segment and 1 Caesarean hysterectomy (10). This woman had a scarred but adequate abdominal wall. During her obstetrical life of 18 years, she had enjoyed good health. She experienced the ministrations of no less than four successive Masters of the Hospital (Healy, Corbet, Keelan, Feeney). Microscopical examination of the scarred uterus showed excessive tissue with, in places, absence of muscle.'¹²⁷

Vaginal delivery remains a key goal within obstetrics today, and is described as a 'normal' birth in contrast to delivery by caesarean, forceps or other medical intervention. The National Health Service in Britain is committed to lowering the section rate in its hospitals, which currently stands at 24.6%¹²⁸, and there are widespread concerns regarding a general misconception regarding the absolute safety of caesarean section: given its prevalence, there is a tendency to underestimate the risks associated with what is major abdominal surgery.¹²⁹ The

¹²⁵ Kenneth Bjorklund, 'Minimally invasive surgery for obstructed labour: a review of symphysiotomy during the twentieth century (including 5000 cases)' in *British Journal of Obstetrics and Gynaecology*, March 2002, Vol. 109, pp. 236–248.

¹²⁶ Clinical Reports for the Dublin Maternity Hospitals, 1944–1984.

¹²⁷ Clinical Report of the Coombe Lying-In Hospital for 1951, p. 29.

¹²⁸ 'Focus on Caesarean Section', *National Health Service Institute*, 2007

¹²⁹ In addition to concerns regarding patient safety, there are also anxieties over the financial implications in increasingly straightened times for the NHS. Costs for a CS patient are over 25%

National Institute for Health and Clinical Excellence in the UK has recently recommended that women in Britain should be offered CS if they wish it, and not primarily, as at present, on medical grounds. Their November 2011 guidelines offer a detailed analysis, and series of recommendations, regarding the increase in caesarean deliveries in Britain, and an acknowledgement of the importance of maternal choice in ensuring a safe and satisfactory delivery.¹³⁰ In the United States, where the CS rate has increased substantially, there are similarly intense debates over vaginal versus CS deliveries.¹³¹ A recent study of the Irish case has revealed substantial differences in section rates across maternity units, from the lowest at 22% of births at the National Maternity Hospital Dublin to a high of 43% at St. Lukes Hospital, Kilkenny.¹³² Nationally, the Irish rate is 26.2% of births, a steadily increasing number. What is little realised is that Caesarean Section still carries a higher maternal mortality rate in the western world than vaginal delivery, and is associated with significant long-term health problems. A recent study in France indicates that: 'After adjustment for potential confounders, the risk of postpartum death was 3.6 times higher after caesarean than after vaginal delivery...Both prepartum¹³³ and intrapartum¹³⁴ caesarean delivery were associated with a significantly increased risk. Caesarean delivery was associated with a significantly increased risk of maternal death from complications of anaesthesia, puerperal infection, and venous thromboembolism.'¹³⁵ Similarly, in Britain caesarean section is the highest single cause of mortality in hospital deliveries at 61%¹³⁶ of all hospital

higher than a normal delivery, with mothers having a hospital stay of 3-4 days, as opposed to just 1, in addition to theatre costs.

¹³⁰ NICE Clinical Guideline, 'Caesarean Section', November 2011, pp. 1-282.

¹³¹ Fay Menacker & Brady E. Hamilton, 'Recent Trends in Caesarean Delivery in the United States' *National Center for Health Statistics Data Brief*, No. 35, March 2010, pp 1-2.

¹³² A recent study by Cuidiú, *The Consumer's Guide to Maternity Services in Ireland*, provides detailed information on relative rates of CS section for first-time mothers as well as sections in subsequent pregnancies. See <http://www.bump2babe.ie/column/P/statistics/> for both the statistics, and analysis for the trends relating to delivery choices.

¹³³ The period before delivery.

¹³⁴ Pertaining to the period during labour and birth.

¹³⁵ Catherine Deneux-Tharoux, Elodie Carmona, Marie-Hélène Bouvier-Colle, & Gérard Bréart, 'Postpartum Maternal Mortality and Caesarean Delivery' in *Obstetrics and Gynaecology*, September 2006, Vol. 108, No. 3, Part 1, pp. 541-8.

¹³⁶ G. Lewis, 'Saving Mother's Lives: reviewing maternity deaths to make motherhood safer, 2003-2005' *The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom* London: CEMACH, 2007, P. 13

maternal deaths.¹³⁷ A large-scale international study of the topic published in 2007 confirmed the relative risks of section delivery, which were higher for elective sections than emergency. Examining a total of 106,546 births over a three month period in eight Latin American countries, the researchers found that:

Caesarean delivery independently reduces overall risk in breech¹³⁸ presentations...[however]...the increase in rates of caesarean delivery at an institutional level is not associated with any clear overall benefit for the baby or mother but is linked with increased morbidity for both...In the crude analysis, the maternal mortality and morbidity index in women in the elective caesarean delivery group (5.5%) was higher than that in the intrapartum caesarean group (4.9%) and vaginal delivery groups (1.8%).¹³⁹

In Ireland in the mid-twentieth century, the maternal mortality rate for caesarean section was much higher, and was a constant source of discussion. Symphysiotomy was therefore regarded by some obstetricians as a means of reducing the number of deaths. In the 'Transactions' for 1961, Dr Gallagher proposed a more extensive study of the possibilities of symphysiotomies: 'I think if we are going to state a policy with regard to CS in Dublin it should be to keep down the number of sections as far as possible. One way of achieving that would be for the three Masters to select 30 cases a year each and do elective symphysiotomies on them.'¹⁴⁰ The suggestion was not implemented, not least because the actual numbers (as opposed to the proportionate use in total deliveries) of symphysiotomies had plateaued, and repeat caesarean sections were becoming increasingly common, as well as safer. The numbers of sections for conditions other than dire emergency in labour were rising, with good results: 'Falkiner [of the Rotunda] was innovative in extending the use of

¹³⁷ Again it is important to emphasise that the section does not necessarily cause the death. In many cases, an underlying medical condition may make a section necessary, but factors such as heart disease, high blood pressure, or pre-eclampsia makes the outlook poor.

¹³⁸ A baby born with feet or buttocks first. Complications in labour are more common with breech deliveries.

¹³⁹ Jose Villar, Guillermo Carrdi, Nelly Zavaleki, Allan Donner, Daniel Wojdyla, Anibal Faundes, Alejandro Velazco, Vicente Bataglia, Ana Langer, Alberto Narváez, Eliette Valladareo, Arichana Shah, Liana Campodónico, Mariana Romero, Sofia Reynoso, Karla Simônia de Pádua, Daniel Giordano, Maricus Kublickas and Arnaldo Acosta, 'Maternal and Neonatal Individual Risks and Benefits Associated with Caesarean Delivery: multicentre prospective study' in *British Medical Journal*, 2007, November 17; 335 (7628) 1025.

¹⁴⁰ 'Transactions' in *Irish Journal of Medical Science*, 1961, p. 536.

caesarean section for conditions other than disproportion and ante-partum haemorrhage from placenta praevia. He used it more liberally than ever before in the management of severe cases of pre-eclamptic toxemia¹⁴¹ of pregnancy, and was criticised for doing so by the Academy. However, as time went by the results fully justified the policy.¹⁴² By the early 1960s, it was becoming increasingly clear that with improved maternal health, and better surgical and anaesthetic techniques, repeat caesareans no longer held the dangers they once had. A short study conducted at the Rotunda confirmed this trend: 'A preliminary study of Multiple Repeat Caesarean Sections from Rounda Hospital Records by Dr Terence Hynes suggests that multiple repeat section in fact constitutes a very small degree of danger to the patient. Out of 115 cases who had already undergone at least three previous Caesarean Sections there was no rupture of the uterus, no maternal mortality and minimal foetal loss.'¹⁴³

Long-term Effects of Symphysiotomy (See Section Two for Patient Responses):

The nature of the procedure, and the potential danger of introducing pelvic instability, was at the forefront of obstetricians' minds from the 1940s. It proved a constant source of discussion at the Royal Academy of Medicine, when Obstetricians of the Royal College travelled to Dublin to discuss the maternity hospital reports, but also between the Masters of the three Dublin hospitals. Many of the reports include detail regarding the short-term impact of the procedure, and present individual case notes up to discharge. Some patients returned for follow-up, but it was more common for mothers to come to hospital only when they were about to deliver their next baby. The Dublin hospital reports provide some detail on the figures (recovery, ambulation, incontinence, pain), follow-up in some cases,¹⁴⁴ and commentary on subsequent vaginal deliveries.

¹⁴¹ A potentially fatal condition of pregnancy characterized by high blood pressure, protein in the urine, abnormal weight gain, and oedema [excessive swelling].

¹⁴² Browne, p. 30.

¹⁴³ Rotunda Hospital Annual Report for 1961, p. 29.

¹⁴⁴ Reporting is not consistent. Many patients failed to attend hospital for follow-up, and in some reports note is taken of women who subsequently underwent a spontaneous vaginal delivery, but does not comment on general health.

In 1955, the Master of the Coombe Hospital published a review of symphysiotomy patients¹⁴⁵ who had undergone the procedure between January 1950 and December 1953, and reported these results¹⁴⁶:

Difficulty in Walking

- 44 experienced no difficulty whatever
- 2 had difficulty after a long walk, of about one mile
- 2 had difficulty “if already tired”
- 1 had a tired feeling in the right leg after a long walk
- 1 complained of difficulty, but this was not substantiated by observation

Difficulty in lifting heavy articles, such as a bucket of water

- 39 experienced no difficulty
- 4 “could not manage” a bucket of water
- 3 felt “uncomfortable” in the pelvis, when lifting such a weighty article
- 2 had difficulty from the 7th month of a succeeding pregnancy
- 1 had “occasional” difficulty in lifting weights

Pain in the back

- 35 had no backache
- 8 had “occasional” backache
- 4 had “fairly constant” backache

¹⁴⁵There were periodic reports of symphysiotomy outcomes throughout the annual reports. The Coombe listed the following results in 1947 from the total of nine women who had undergone the procedure that year:

No. 23: ‘...patient up on 9th day – discharged on 16th day. Follow up: three months later – no disability.’

No. 24: ‘...discharge on 17th day – no disability. Returned 4 weeks later with frequency of micturition – cystitis, which yielded quickly to Sulphonamides. Two months later – quite well.’

No. 25: ‘...Patient discharged well on 17th day. Attended the Academy of Medicine walking perfectly on 16th day. Follow up not possible.’

No. 26: ‘...Patient discharged on 16th day walking well. Came back 3 days later complaining of some pain in region of wound. There was local sepsis, wound was incised, and sepsis cleared up perfectly in 4 days. Left hospital without x-ray. Follow up impossible.’

No. 27: ‘Patient up on 9th day. Discharged free of all disability on 16th day. Returned 2 months later complaining of slight stress incontinence. On examination with bladder full this could not be demonstrated when lying down, but was evident in the erect position. Still under observation.’

No. 28: ‘...Patient up on 10th day, discharged, walking well and without disability on 16th day. Two months later – no disability.’

No. 29: Discharged on 19th day.

No. 30: ‘...Patient up on 10th day, discharged walking perfectly on 14th day.

No. 31: ‘no comment on condition after operation.’

¹⁴⁶ Report of the Coombe Maternity Hospital for 1954, pp. 55-6.

2 had backache "during the period"

1 had backache in the late weeks of a succeeding pregnancy

Incontinence of urine

38 had normal control over micturition

2 had poor control with "bad cough"

2 had defective control, but only in last two months of a succeeding pregnancy

1 had defective control in bad weather

1 had defective control for 3 months after symphysiotomy, but then regained continence

1 had defective control when pregnant next time, in cold weather and just before menstruation

1 had slight incontinence on sneezing

1 had to "run" when she "felt the impulse"

1 had poor control "at intervals"

1 had poor control

And in 1, stress incontinence had preceded symphysiotomy and has since been cured by sub-urethral repair

Other complaints which might be connected with the operation

1 complained of "deadness" in one leg on long standing

1 complained of "coldness" and "pain" in one leg

1 complained of "coldness" in one leg during period and when pregnant next time

1 complained of "occasional weakness" in legs

1 complained of "a feeling of strain" in the pelvis

Pregnancy following symphysiotomy

21 patients each had one spontaneous vertex¹⁴⁷ delivery of a living infant

1 patient had an easy assisted breech delivery of a living 9lb foetus

4 women had each 2 spontaneous vertex deliveries

3 women each had 3 spontaneous vertex deliveries

¹⁴⁷ Baby delivered head first.

1 patient had, to follow the symphysiotomy, one Caesarean Section and then 2 easy vaginal deliveries

1 patient had, to follow the symphysiotomy, one Caesarean Section (spondylolisthesis),¹⁴⁸ not suitable for symphysiotomy in the first instance

1 had a spontaneous delivery of a large postmature macerated¹⁴⁹ foetus

1 patient had an abortion

1 patient had a miscarriage

16 patients have not become pregnant so far

As is well established, reported pain following any injury or medical intervention is highly individual, and assessments are likely to be effected by the expectation of both the patient and the physician. Patients undergoing identical procedures will report a wide variety of responses, good and bad, that offer very different perspectives on treatment. Moreover, the questions asked of a patient will have a significant effect upon their response, and the manner in which it is recorded. The relationship between patient and practitioner will also effect, if not predetermine, the outcome. This is noted in the results above: the Master somewhat paternalistically notes that he did not himself interview the patients at follow-up, in order to avoid the personal relationship from influencing the women's responses: 'In case the answers of the patients to specific questions might be coloured by any gratitude which they might feel, the interviews were not carried out by me.'

The early conclusions appear to be supported by follow-up reports from the modern developing world. A number of studies of long-term effects have been conducted,¹⁵⁰ which concur broadly with the Dublin reports. A study of a small cohort of 34 women after symphysiotomy in Zimbabwe in 2008 for example found the following results: 'None reported serious soft tissue injuries in the birth canal e.g. laceration, fistulae, and haemorrhage, or post-operative infection. One suffered stress incontinence, eight reported pain on walking, seven of them after 10-20 kilometres. One woman

¹⁴⁸ Forward displacement of one of the lower lumbar vertebrae over the vertebra below it or on the sacrum.

¹⁴⁹ A stillborn infant with skin and tissue softening.

¹⁵⁰ There are methodological problems with these reports, which are acknowledged by authors, in that patient return for follow-up is even more erratic than in the mid-twentieth century Irish case. The criteria for inclusion are however clearly laid out, and the results, although relatively small-scale, are verifiable.

(stress incontinence above) who delivered a baby with hydrocephalus¹⁵¹ had pain in symphysis pubis and a feeling of instability in pelvis when walking any distance...the results from the present study and previous follow-up studies indicate that symphysiotomy confers an acceptable level of complaints in the long run.'¹⁵² A follow-up study of 100 South African patients in 1963 specifically addressed the issue of pain, examining the symphysis pubis, groin, hip, thigh, sacro-iliac joint and evaluating stress incontinence. It was found that there were some long-term effects, but negative reports were slightly higher amongst the control group of women who had had a normal vaginal delivery. 60% of this group reported some or all of the symptoms during the follow-up period or in a subsequent pregnancy, compared with 58% of the symphysiotomy patients. Tests included walking, running, jumping and carrying weights.¹⁵³ In 1975, the results of a Nigerian study comparing outcomes of symphysiotomy with caesarean section were published. It found that long-term effects were similar with both procedures, with the two cohorts reporting sub-fertility (7%), stress incontinence (3%) and backache (25%).¹⁵⁴ A comparative study of symphysiotomy (86 patients) and caesarean section (920) in New Guinea showed better outcomes for the symphysiotomy patients in terms of maternal mortality and morbidity¹⁵⁵, and so on.

There is no doubt that some women have suffered adverse effects from the procedure, and in the case of patients who went on to have subsequent children, there may well have been an exacerbation of operative injuries. Part of the problem in assessing long term problems after symphysiotomy is that other factors, including subsequent pregnancies, may themselves contribute to chronic ill health.

Incontinence occurs in approximately 10% of women as a result of normal

¹⁵¹ A condition in which fluid accumulates in the brain, typically in young children, enlarging the head and sometimes causing brain damage. Babies with hydrocephalus were difficult to deliver, and the condition accounted for a number of symphysiotomies in Dublin in the 1940s and '50s in particular.

¹⁵² Henge Langi Ersdal, Douwe A.A. Verkuyl, Kenneth Bjorklund & Staffan Bergström, 'Symphysiotomy in Zimbabwe; Postoperative Outcome, Width of the Symphysis Joint, and Knowledge, Attitudes and Practice among Doctors and Midwives' in *PLoS One*, 2008, Vol. 3(10), e3317. See also Staffan Bergström, H. Lublin, & A. Molin, 'Value of symphysiotomy in obstructed labour management and follow-up of 31 cases' in *Gynecologic and Obstetric Investigation* 1994, No. 38, pp. 31–5.

¹⁵³ A.H. Lasbrey, 'The Symptomatic Sequelae of Symphysiotomy: a follow-up study of 100 patients subjected to symphysiotomy' in *South African Medical Journal* 1963; vol. 37, pp. 231-234.

¹⁵⁴ V.J. Hartfield, 'Late Effects of symphysiotomy' in *Tropical Doctor* 1975, Vol. 5, pp. 76-78.

¹⁵⁵ G. Mola, M. Lamang, ad I. Mcgoldrick, 'A retrospective study of matched symphysiotomies and caesarean sections at Port Moresby General Hospital' in *Papua New Guinea Medical Journal* 1981; 24: 103-112.

pregnancy and delivery,¹⁵⁶ and incontinence may set in long after delivery: women with temporary loss of urinary control immediately after delivery which resolves itself are in fact three times more likely to suffer incontinence in the five years following delivery than women without children.¹⁵⁷ There are also well established links with long-term pelvic girdle pain and pregnancy (<http://www.pelvicgirdlepain.com/>). When the media first began to cover the story of symphysiotomy in Ireland, many women approached the hospitals where they had delivered, as they had suffered long-term health problems after births including incontinence and chronic back pain. They now feared that they had had symphysiotomies, and as many patients had not been aware that they had undergone the procedure, this was an understandable reaction. In one hospital for example, nine women came forward, of whom two had actually undergone the procedure. 'Normal' pregnancy and delivery can carry a significant morbidity rate, an element that needs to be addressed as part of any review of symphysiotomy.

The Decline in Symphysiotomy:

The procedure went into increasing decline from the early 1960s. There are several key reasons:

- Improvements in maternal health, that significantly reduced the risks of pregnancy and delivery. These included better nutrition and housing, and improved medical provision under the Health Act of 1953¹⁵⁸
- Increasing use of repeat Lower Section Caesarean Section, as evidence indicated that the established 'Three Caesarian Rule' pertaining to the 'Classical Section' was outmoded

¹⁵⁶ E. Eason E et al. 'Effects of carrying a pregnancy and of method of delivery on urinary incontinence: A prospective cohort study.' *Bio Medical Central Pregnancy and Childbirth* 2004, 4:4. See also Thom D et al. 'Evaluation of parturition and other reproductive variables as risk factors for urinary incontinence in later life' in *Obstetrics and Gynaecology* 1997, Vol. 90 (6), pp. 983-9.

¹⁵⁷ S. Stanton, R. Kerr-Wilson & V. Grant Harris, 'The incidence of urological symptoms in normal pregnancy' in *British Journal of Obstetrics and Gynaecology*, 1980, Vol. 87, pp. 897-900.

¹⁵⁸ Under this act, women were entitled to a full maternity service, and could choose their own doctor or midwife. They also had the option of private care for a fee in nursing homes. 'Comprehensive medical and nursing care for their infants was also provided for. Maternity cash grants of £4 for each birth were introduced for women in what became known as the lower income group. A requirement on health authorities to provide child welfare clinic services was substituted for the permission to do so.' Brendan Hensey, *The Health Services of Ireland* (2nd revised edition, Dublin: Institute of Public Administration, 1972), p. 25

- Increasing use of drugs such as oxytocin to shorten labour, reducing the need for symphysiotomy
- A growing realisation, shared with obstetricians in Britain, that pelvic disproportion had been over-diagnosed

Maternity care in Ireland, in common with the rest of the western world, improved steadily throughout the twentieth century. The World Health Organisation's report on *Maternal Mortality in 2005* confirms an exceptionally low rate of maternal mortality in twenty-first century Ireland, the lowest in the world. Maternal mortality is now grossly unevenly distributed, with an astonishing 99% of pregnancy and labour-related deaths occurring in the developing world, where an estimated 536,000 women die each year.¹⁵⁹ Ireland's preeminent position makes the condition of women in the developing world truly devastating to contemplate. WHO defines the risk of maternal mortality as the likelihood that a '15-year-old female will die eventually from a maternal cause...Of all 171 countries and territories for which estimates were made in 2005, Niger had the highest estimated lifetime risk of 1 in 7, in stark contrast to Ireland, which had the lowest lifetime risk of 1 in 48 000.'

The early 1960s marked a turning point in terms of the use of symphysiotomy in Ireland. Post-war improvements in housing, nutrition, and hospital care had made a dramatic impact upon maternal health, and legislative change such as the Health Act of 1954, which established a public health care system, now offered a basic level of care to the impoverished. TB had been brought under control, rates of chronic illness such as rheumatic heart disease were lowered, and there was direct intervention in public health to control infectious disease.¹⁶⁰ Public housing schemes began, and

¹⁵⁹ 'Of the estimated total of 536 000 maternal deaths worldwide in 2005, developing countries accounted for 99% (533 000) of these deaths... By the broad MDG [Millennium Development Goals – the WHO's stated targets for improvements in maternal health care] regions, MMR [Maternal Mortality Rate] in 2005 was highest in developing regions (at 450 maternal deaths per 100 000 live births), in stark contrast to developed regions (at 9) and countries of the commonwealth of independent states (at 51). These countries are (listed in descending order): Sierra Leone (2100), Niger (1800), Afghanistan (1800), Chad (1500), Somalia (1400), Angola (1400), Rwanda (1300), Liberia (1200), Guinea Bissau (1100), Burundi (1100), the Democratic Republic of the Congo (1100), Nigeria (1100), Malawi (1100), and Cameroon (1000). By contrast, Ireland had an MMR of 1.' World Health Organisation, *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank* (WHO Press, 2007), p. 1.

¹⁶⁰ The recent TV3 documentary series 'The Tenements' gives an idea of the conditions under which large families lived, and an indication of how the new suburban developments were heralded as a great advance.

moved families from one-room tenements to flats on the outskirts of the city.¹⁶¹ Moreover, there had been advances in medical care that led to symphysiotomy's decline. Obstetricians found that quickening the pace of labour eliminated the need for such intervention, and new drugs such as oxytocin which accelerated labour, produced vaginal deliveries without the need for symphysiotomy. One of the indicators for symphysiotomy was inertia during labour. This had been overcome by symphysiotomy, which in allowing the baby's head to descend, had advanced the process. Although modern practice questions excessively rapid labour, in the 1960s it was heralded as a safe and positive advance, effectively eliminating the horrendous marathon labours of 50 and 60 hours that had occurred in the 1940s. The impact of wider changes in Ireland were noted by the British obstetricians. In the discussions for 1965, Ian Donald of Glasgow commented: 'There are details in looking back over 10 years but the general picture is one of clearly increased social wellbeing with less of the diseases that go with bad social conditions.'¹⁶² At the same meeting he made specific comment on symphysiotomy, with a prescient indication of its future application: 'After the last meeting in 1955 I came away from Dublin more impressed with symphysiotomy than I would be today. It seems to be dying a natural death. I could find none mentioned in the Coombe record, only 5 at the National as compared with 33 cases ten years ago, and 4 at the Rotunda, one of whom still had to be delivered by CS. In one of the cases the uterus was ruptured. I can't help feeling that this is attempting to secure delivery per vaginam at too high a price. I am still, however, convinced of the value of symphysiotomy in underdeveloped communities such as in East Africa where patients disappear into the bush for their next baby after a Caesarean section and where at Makerere, which I visited last summer, 25 per cent of uterine ruptures are in previous Caesarean section scars.'¹⁶³ Only a year later, the further decline in symphysiotomy excited notice. Prof Geoffrey Dixon of Bristol recorded: 'The low incidence of symphysiotomy in all units has tempted me into venturing into a prophecy of what your invited speaker will have to show for symphysiotomy in 10 years time i.e. 0.0%. There seem to me two possible explanations for this falling incidence, either you are adopting a UK policy in

161 This was to prove a mixed blessing. Although living conditions vastly improved in the new accommodation, some families found themselves isolated in the new estates, and mothers often found it difficult to afford the bus fare to travel to the city hospitals for check-ups.

¹⁶² 'Transactions' in *Irish Journal of Medical Science* 1965, p. 55.

¹⁶³ *Ibid*, pp. 58-9.

relationship to Caesarean Section and symphysiotomy, or improved nutrition in Dublin is bringing your patients' pelvis into line with their UK sisters. The figures from the Rotunda and the comments from the Coombe and the National suggest that the latter is the true explanation.'¹⁶⁴

Continual evaluation of caesarean section, especially repeat sections, were a feature of the Dublin annual reports, and the findings were shared between the three hospitals. The Rotunda was particularly interested in the safety of repeat operations, as symphysiotomy was used there far less than in the NMH and the Coombe. In 1961, the Master reported: 'A preliminary study of Multiple Repeat Caesarean Sections from Rounda Hospital Records by Dr Terence Hynes suggests that multiple repeat section in fact constitutes a very small degree of danger to the patient. Out of 115 cases who had already undergone at least three previous Caeseaeen Sections there was no rupture of the uterus, no maternal mortality and minimal foetal loss.'¹⁶⁵

Despite the decline in symphysiotomy use in Dublin, however, the practice was not yet out of favour in other hospitals:

Our Lady of Lourdes Hospital, Drogheda:

As concern has been expressed regarding rates of symphysiotomy at Our Lady's, it is appropriate that this draft report specifically examines the practice here; figures from other national maternity centres suggest a lower usage. Although rates of symphysiotomy in Our Lady's appears to reflect the proportionate usage elsewhere, the preliminary figures indicate that the practice continued at the hospital far later than at any other institution. Symphysiotomy was still in use in the hospital as late as 1984, albeit in very small numbers. Published reports for Our Lady of Lourdes Hospital are not available for the entire period of this study. There are clinical reports from 1959 to 1984, which provide statistical detail on deliveries, and the relative rates of symphysiotomy and caesarean section.

¹⁶⁴ Transactions, *Irish Journal of Medical Science*, 1966, p. 551.

¹⁶⁵ Clinical Report of the Rotunda Hospital for 1961, p. 29.

Our Lady of Lourdes Hospital, Drogheda: comparative symphysiotomy and caesarean section rates:¹⁶⁶

YEAR	No. Of Symphys	Symphs as % of births	Mat Deaths Symph	Foetal Deaths Symph	No. Of CS	CS as % of births	Mat Deaths CS	Foetal Deaths CS	Total Deliveries
1958	21				44		0	2	
1959	14	0.9	0	0	44	2.9	0	7	1,495
1960-61	48	1.5	0	5	89	2.8	0	6	3,203
1962-63	40	1.1	0		87	2.5	0	5	3,500
1964-65	22	0.5	0	2	127	2.9	0	5	4,411
1966-67	31 ¹⁶⁷	0.6	0	0	152	3.0	1	11	5,014
1968-69 ¹⁶⁸	19 ¹⁶⁹	0.3	0	2	183	3.4			5,435
1970-71	26	0.5	0	1	199	3.4	1	22	5,771
1972-73	15	0.3	0	0	186	3.3	0	11	5,702
1974-75	8	0.1	0	0	203	3.5	0	8	5,725
1976-77	9	0.1	0	0	222	3.6	0	12	6,088
1978-	4	0.06	0	0	281	4.4	0	8	6,348

¹⁶⁶ The hospital produced a combination of annual and biannual reports as indicated, therefore in some years the figures address a 12 month period rather than a 24.

¹⁶⁷ 7 of these symphysiotomies were 'performed after delivery, and during closure of abdominal wound [often referred to as "symphysiotomy on the way out"]'.

¹⁶⁸ The 1968-69 Report contained a summary of cases of symphysiotomy. 'There has been a steady decrease in the use of symphysiotomy throughout the sixties. The operation was performed on a total of 160 cases [1960-69] with these results:

Vaginal Delivery: 135

Caesarean Section 11

Symphysiotomy on "way out" after CS 14

There were 9 foetal deaths: 5 of congenital malformation, 3 asphyxial death, and 1 traumatic I.C.H. [intracranial haemorrhage]

¹⁶⁹ 3 "on way out".

79									
1980	3	0.09	0	0	178	5.5	0	5	3,235
1981	1	0.03	0	0	169	5.6	0		2,998
1982	3	0.1	0	0	170	6.3			2,708
1983	1	0.03	0	0	184	7.0			2,628
1984	3	0.1	0	0	243	10.1	0	8	2,399

The patterns at Our Lady's suggests a broadly equivalent use of the procedure in relation to the Dublin hospitals (0.4 of the total deliveries at Lourdes, as opposed to an aggregate of 0.36 for the NMH and the Coombe¹⁷⁰). However, this is not an accurate picture as it excludes the period in which it was at its height in Dublin, the late 1940s and early 1950s. The procedure had a far lower maternal and foetal mortality rate than caesarean section, with no maternal deaths and 10 foetal for symphysiotomy, against 2 maternal and 110 foetal deaths for section.

Judge Maureen Harding Clark's report into peripartum hysterectomy at Our Lady's investigated not merely the use of the procedure, but the broader culture that existed at the hospital. That report found a unique situation: one in which consultants, Gerard Connolly (the founding obstetrician) in particular, were obeyed by the nursing and management staff without question. The ethos was unswervingly Catholic, with an absolute ban on artificial contraception even when it was both legal, and broadly accepted, in other maternity hospitals and indeed in the country at large.¹⁷¹ Connolly cast a long shadow over obstetric practice at Our Lady's. The persistence of symphysiotomy at the hospital twenty years after it had largely ceased elsewhere in Ireland appears to be specifically linked with Connolly's tenure. Michael Neary reported that Connolly 'was a firm believer in carrying out symphysiotomies in the hopes of avoiding caesarean section and in this was influenced by Dr. Arthur Barry, the former Master of Holles Street Maternity Hospital.'¹⁷² However, the context in which symphysiotomy took place at Our Lady's in the 1970s and '80s is very different from that of the 1950s, when Barry advocated the procedure.

¹⁷⁰ The Rotunda figures are excluded from this calculation as they were so low in relation to births that inclusion would produce an artificially low overall figure for the three hospitals.

¹⁷¹ Astoundingly, Connolly was prepared to undertake caesarean hysterectomies and render a woman permanently infertile, rather than permit artificial contraception, which could easily be reversed. Harding Clark, p. 233.

¹⁷² Harding Clark, p. 233.

The investigation into general obstetric practices at Our Lady's revealed a centre dominated by one consultant, with a narrow range of experience and training, whose dedication to the hospital and its patients apparently precluded criticism. Connolly continued practices that were increasingly outmoded in the 1970s and early 1980s: his occasional use of the 'Classical Section' (also utilised by Neary) for caesarean delivery rather than the widely accepted and less traumatic Lower Segment Section was heavily criticised. Connolly's continued use of symphysiotomy at a much later period than other obstetricians also appears to be part of this autocratic, old-fashioned system. Harding Clark noted that the lack of ongoing training for practitioners at Our Lady's contributed to inadequate standards, and this may well be an element in the hospital's continued use of symphysiotomy. The procedure was used in the same clinical situations as in Dublin (mild to moderate disproportion), and at similar proportionate rates, but its persistence when it had largely disappeared elsewhere puts it outside accepted practice. All of the factors that saw symphysiotomy's national decline were also present at Drogheda (safer LSS deliveries, better maternal health, use of oxytocin in labour), therefore one would expect to see Our Lady's follow the same pattern.

The production of annual clinical reports at Our Lady's was specifically investigated by Harding Clark. It had originally been intended by Our Lady's that the Drogheda reports be published at the same time as the Dublin maternity hospital reports, in order to compare practice, but this was generally not achieved until the 1980s.¹⁷³ If that original intention had indeed been fulfilled, and if either the Royal College of Obstetricians and Gynaecologists in London or the Institute of Obstetricians and Gynaecologists in Dublin (after 1976) had been formally required to review the reports, Our Lady's continued use of symphysiotomy would have been noticed. Connolly appeared to view maternity care in the 1970s and '80s as if it were still the 1950s, and his refusal to countenance contraception, and to approach deliveries in the belief that caesarean section was still potentially dangerous, ensured that he retained a faith in symphysiotomy as a solution to obstructed labour.

There is another unusual element in the Drogheda hospital. The symphysiotomies performed at Our Lady's include a high number of elective procedures, which would

¹⁷³ Harding Clark, *Inquiry*, p. 286.

have been carried out with patient consent: there were nine elective symphysiotomies out of 40 in 1962-3 for example, amounting to almost a quarter of the total. This is a different pattern from other centres, where the procedure was used in the majority of cases during labour, and in a smaller number 'on the way out'. Despite the major deficiencies in Connolly's obstetrical record, the Harding Clark Inquiry found that many patients as well as colleagues spoke highly of his skill and dedication to his work,¹⁷⁴ and it is not improbable that some patients who underwent symphysiotomy did so willingly on his professional advice.¹⁷⁵ Connolly's own evaluation of symphysiotomy does not suggest a commitment to the procedure at all costs, and he appeared to welcome its gradual decline.¹⁷⁶ However, the fact that it persisted for so long at Our Lady's when alternative methods for dealing with difficult deliveries were available is unacceptable.

Allegations have been made that symphysiotomy at Our Lady's was employed for training purposes, to improve techniques for use in the Medical Missionaries of Mary hospitals in Africa, and the use of procedure at a later stage than other maternity hospitals has been described as 'experimental'.¹⁷⁷ This is a serious allegation, implying that some symphysiotomies were carried out unnecessarily to facilitate training, and must be a cause of enormous distress for women who underwent the procedure. There appears however to be no evidence to support the assertion. Our Lady's was an approved training centre by the Royal College of Obstetricians and Gynaecologists. Moreover, the observation of procedures is a long established, and

¹⁷⁴ *ibid*, pp. 162-4.

¹⁷⁵ This can be verified only through an examination of individual patient case notes.

¹⁷⁶ His comments in the annual reports indicate his changing attitude towards the procedure:

'[one case in 40 symphysiotomies developed stress incontinence which]...was successfully treated by suburethral repair. The more frequent use of oxytocin drip and the vacuum extractor will, undoubtedly, help to reduce the need for symphysiotomy (Clinical Report for 1962 & 1963).'

'The oxytocic drip was used much more frequently in the two years under review, than in previous years. There is no doubt that it is a great asset in shortening labour, and it has reduced the number of patients requiring symphysiotomy for borderline disproportion (Clinical Report for 1964 & 1965).'

'[Commenting on changing indication for the procedure] The 26 cases were all delivered vaginally of living infants, except for one neonatal death due to hydrocephalus. All cases were done in labour, 25 being performed in the second stage of labour. There were 10 breech deliveries and one face presentation. The incidence of this operation has been unchanged over the last 8 years. However, the operation now is nearly always done in the second stage of labour and never electively or during closure of the abdominal wound after a caesarean section (Clinical Report for 1970 & 1971).'

¹⁷⁷ Marie O'Connor, *Bodily Harm* (Dublin: Johnswood Press, 2011), pp 117-18.

indeed central element in medical and nursing training, and has been part of Irish medical training from the eighteenth century.¹⁷⁸ The presence of trainee or junior doctors in theatre was common, and the practice of securing permission from the patient a relatively recent development.¹⁷⁹ The assertion does not appear to be supported by the patterns of delivery at Our Lady's. Symphysiotomy declined steadily from the mid 1960s, and the caesarean section rate rose at an equally steady rate: one would expect the operation to be employed to a greater extent, and a lower CS rate lower as a consequence, to support its inappropriate use as a training tool.

Symphysiotomy 'On the Way Out':

The context for the reintroduction and eventual decline in symphysiotomy in Ireland has been examined. When the procedure was first discussed by obstetricians in the 1940s it was regarded as an appropriate response to specific situations, namely mild to moderate disproportion at delivery. As such, it was an acceptable medical response to a serious condition, as it remains in parts of the modern world. However, there is an additional element in its application in certain hospitals in Ireland that does not conform to standard practice, and that is its use as a prophylactic procedure, in advance of labour and delayed delivery, and indeed in advance of pregnancy. Often referred to as symphysiotomy 'on the way out', this is a deviation from good practice.

Symphysiotomy 'on the way out' referred to the practice of performing the procedure immediately after a caesarean section. It occurred when a woman had already delivered her baby by section, and her abdominal wound was being stitched: the obstetrician then partially cut the symphysis pubis. It was done in cases where the obstetrician believed that the patient was suffering from a relatively mild degree of disproportion, and would be able to deliver her next baby vaginally. Because the procedure was performed without labour, the degree of pelvic widening was less than in the usual symphysiotomy: this, it was argued, would avoid the danger of

¹⁷⁸ Toby Barnard, 'The Wider Cultures of Eighteenth-Century Irish Doctors' in James Kelly and Fiona Clark (eds) *Ireland and Medicine in the Seventeenth and Eighteenth Centuries* (Surrey: Ashgate Press, 2010), p. 185

¹⁷⁹ There is international agreement regarding the necessity for informed patient consent to observation and a very high rate of agreement from patients, especially in teaching hospitals – see 'Informed Consent Process important to Surgery Patients in Teaching Hospital' in *ScienceDaily*, September 19, 2011.

pelvic instability, but still produce the fractional expansion needed to deliver the next baby naturally (the scar tissue laid down during healing marginally widened the pelvic diameter). Also referred to as 'Prophylactic Symphysiotomy' (prophylactic meaning a measure taken to prevent a disease or condition), it is a use of the procedure that appears to have little clinical justification.¹⁸⁰ There are several important issues:

- Symphysiotomy was and is appropriate only during labour, when the degree of disproportion can be evaluated (see attached bibliography for reviews on appropriate use of the procedure)
- A woman diagnosed with disproportion in one pregnancy may have a normal delivery in the next, and require neither symphysiotomy or caesarean section
- A decision to undertake a symphysiotomy in an emergency situation may be clinically justified for the safety of the mother and child, but a non-emergency application, while the mother is under general anaesthetic, appears indefensible
- The potential benefit of symphysiotomy before labour, and indeed before pregnancy, was speculative, and flew in the face of acceptable practice (see below)

Some obstetricians argued that symphysiotomy 'on the way out' was appropriate in certain cases of moderate disproportion, and that a subsequent pregnancy would be successfully delivered vaginally once the pelvis was enlarged. But this application of symphysiotomy violates several principles of good practice that prevailed both in the 1950s and '60s, and today. From the earliest consistent use of symphysiotomy, there was general agreement that it was appropriate only in very specific circumstances. Archibald Donald¹⁸¹ identified its use in emergency deliveries in 1896, and E.

¹⁸⁰ It differed from elective symphysiotomy in that the latter was employed in the advanced stages of pregnancy, often days before labour (very occasionally more than a week). It was advised in cases of diagnosed disproportion, in order to avoid the dangers of a trial labour that was likely to fail to proceed. It appears to have been undertaken in consultation with the mothers, and, as such, was a 'negotiated' medical decision.

¹⁸¹ Pioneer of the Manchester-Fothergill operation to repair prolapse in young women subsequent to delivery.

Hastings Tweedy¹⁸² reviewed its use in 1910. He described five degrees of contraction, and recommended symphysiotomy only in degree three:

with a conjugate measuring between 3¼ in and 2¾ in. With such measurements, normal delivery is neither to be looked for nor expected....If the woman is long in labour, with the membranes ruptured, symphysiotomy or pubiotomy should be proferred....Much has recently been heard of the operations of symphysiotomy, pubiotomy, and hysterectomy, and many think they are simply rivals to classical Caesarean Section. Were this so, I should not be concerned in recommending them to your consideration. They neither compete with Caesarean Section nor even with each other; they are complementary operations, each with its own field of usefulness. Until this is clearly realised it will be impossible to stay the present sacrifice of life which has resulted, and must result, from such obsolete procedures as induction of premature labour, prophylactic turning, high forceps, and perforation. It is only a matter of a few years before all these methods will be viewed with the utmost abhorrence. Not only will it be considered criminal to perforate the head of a living child, but to permit one to die because of delay in delivery or from obsolete methods will rightly be condemned. Symphysiotomy or pubiotomy is to be highly recommended.¹⁸³

Irish obstetricians from the 1940s similarly emphasised the limitations of symphysiotomy, and identified its best usage. Although there were no agreed clinical guidelines, it was repeatedly stated that its principal use was as an emergency intervention in very specific cases of disproportion that emerged, for the most part, during delivery: in effect, the indications for symphysiotomy could only truly be determined during labour. Even Arthur Barry, who was an active proponent of the procedure, proposed its use only in labour:

¹⁸² Master of the Rotunda Hospital.

¹⁸³ 'Modern Methods of Delivery in Contracted Pelvis' in *Proceedings of the Royal Society of Medicine*, 1910: 3 (Obstetrics and Gynaecology Section).

When should the operation be performed? The answer to this is comparatively simple. The operation should be carried out: (a) in all young primigravidae¹⁸⁴ with pelvic contraction undergoing trial labour when the natural powers are failing to overcome the obstruction; (b) in all multigravidae¹⁸⁵ with disproportion sufficient to cause obstruction; (c) in all cases of failed forceps due to contracted outlet if the child is alive; (d) in face presentation with the chin posterior and in brow presentation, where efforts at correction have failed; (e) in all young primigravidae with contracted pelvis selected for trial labour in whom early rupture of the membranes or inertia occurs. In such cases it is better to do the operation too early than too late, as delay may result in loss of the baby. The operation should not be employed unless the true conjugate¹⁸⁶ is at least 8.5 centimetres. Size and moulding of the foetal head may occasionally alter this rule.¹⁸⁷

Predicting likely difficulties in labour is, and always has been, an inexact science. As Prof. C. Scott Russell of Sheffield noted in 1951 when discussing diagnoses of disproportion ‘...most of us I suppose use the term to describe a state of affairs in which the normal course of labour is likely to be, or is, disturbed because of insufficient room in the birth canal for the passage of the foetus. Such a definition draws immediate attention to the fact that we cannot always tell if labour is to be upset because of supposed disproportion until after the labour is over. We can be wise after the event: in our speciality this is not very helpful.’¹⁸⁸ Many women with histories of uncomplicated deliveries suffer complications in later labours, and vice versa. Thus undertaking an operation that interfered with the skeletal structure was a serious decision, a fact underpinned by its use in Ireland in relatively small numbers

¹⁸⁴ A woman who is pregnant for the first time.

¹⁸⁵ A woman who is pregnant and has been pregnant at least twice before.

¹⁸⁶ In obstetrics this is defined as ‘the shortest pelvic diameter through which the foetal head must pass during birth, measured from the promontory of the sacrum to a point a few millimeters from the top of the pubic symphysis’ (*The American Heritage Medical Dictionary*, 2007). An accurate measurement is crucial in cases of symphysiotomy, as this is the single most important factor in determining its employment. A smaller conjugate would indicate a caesarean section rather than a symphysiotomy.

¹⁸⁷ Arthur P. Barry, ‘Symphysiotomy or Pubiotomy: Why? When? And How?’ in *The Irish Journal of Medical Science* Sixth Series, No. 314, February 1952, pp 50-51.

¹⁸⁸ ‘Transactions’ in *Irish Journal of Medical Science*, 9th October, 1951, p. 1022.

of mothers. In the review of modern literature undertaken for this report, only material published in international scientific journals, with verifiable statistics and clear methodologies, was used to assess the procedure. Thus the publications represent peer-reviewed, scientifically credible research, and not speculative reviews. No author in these papers proposes prophylactic symphysiotomy, nor any equivalent to symphysiotomy 'on the way out'.¹⁸⁹ All deal with its value in emergency deliveries, especially in cases of cephalopelvic disproportion. There are additional specific circumstances under which the procedure offers the best chance of saving the baby's life, and the rapid delivery of a breech baby, whose head is trapped at the last moment, is one strong indication.¹⁹⁰ This is described as the 'most dreaded complication of the breech vaginal delivery', because of the lack of time to save the baby, and occurs in approximately one in every five hundred breech deliveries.¹⁹¹ A similar emergency indication is in cases of shoulder dystocia,¹⁹² where problems arise after the head has been delivered.¹⁹³ These cases, in addition to the well-established application in disproportion, justify a clinical decision to use symphysiotomy. As a recent Indian study emphatically states: 'Symphysiotomy should only be done in an established case of obstructed labour but not in anticipation of obstructed labour.'¹⁹⁴ Mid-century obstetricians were aware of the appropriate conditions for the use of symphysiotomy. In successive Royal Academy of Medicine Transactions, and severally in the Dublin hospital reports, there was

¹⁸⁹ Belgian obstetricians had reported on prophylactic symphysiotomy in the 1930s. See Bjorklund, *Minimally Invasive surgery*, p. 241.

¹⁹⁰ A discussion of the possible role of symphysiotomy in breech deliveries in Canada indicates the relatively rare, but potentially fatal, case of 'entrapment of the aftercoming head.' 'In more than 30 years of obstetric practice, I am unaware of a symphysiotomy ever having been carried out in a hospital or region where I have served. At the same time, I am aware of only two instances of entrapment of the aftercoming head during vaginal breech delivery in those same centres, and the newborn outcomes were tragic.' The article considers the possible use of symphysiotomy in these exceptional circumstances in Canada, where a sophisticated medical system should eliminate long-term health risks to the mother. David Young, 'Why Vaginal Breech Delivery Should Still Be Offered' in *Journal of Obstetrics and Gynaecology Canada*, 2006, Vol 28, No. 5, pp. 386-89.

¹⁹¹ Savas Menticoglou, 'Symphysiotomy for the Trapped Aftercoming Parts of the Breech: a review of the literature and a plea for its use' in *The Australian & New Zealand Journal of Obstetrics & Gynaecology*, Vol. 30 No. 1, pp. 1-9.

¹⁹² An obstetrical emergency that occurs when the anterior (the front) shoulder of the baby becomes lodged behind the superior symphysis pubis, preventing further delivery. Shoulder dystocia is not always preventable, and is usually not recognized until after the head has been delivered, and gentle downward traction of the fetal head fails to accomplish delivery. It is believed to occur in approximately 2% of deliveries.

¹⁹³ T. Murphy Goodwin, Erika Banks, Lynnae K. Millar & Jeffrey P. Phelan, 'Catastrophic Shoulder Dystocia and Emergency Symphysiotomy' in *American Journal of Obstetrics and Gynaecology*, 1997, Vol. 177, pp. 463-4.

¹⁹⁴ A.P. Choudhury, B. Bhadra & A. Roy, 'Practical Symphysiotomy: an overview' in *Journal of the Indian Medical Association* August 2010, vol. 108, No. 8, pp. 503-4.

agreement regarding the limited conditions under which it should be performed: it was a response to an emergency situation. Although disproportion might be suspected, the generally accepted policy, expressed through the 'Transactions', was to 'wait and see'. If labour failed to advance, then it would be clearer as to whether symphysiotomy or caesarean section was indicated.

The Rotunda performed very few symphysiotomies. Although not under the control of avowedly Catholic Masters in this period, the patients were predominantly Catholic, and the broad medical philosophy similar to that of the Coome and the NMH. The problems of disproportion and obstructed labour facing the other two hospitals were shared by the Rotunda, and were a constant source of anxious discussion. While successive Masters expressed more overt concern regarding symphysiotomy, it was the Rotunda that explored the procedure 'on the way out' before the other Dublin hospitals, and employed it to a greater extent, albeit in tiny proportionate numbers. In 1952 for example there were seven symphysiotomies at the Rotunda, all 'performed at Caesarean section to facilitate vaginal delivery in future pregnancies.'¹⁹⁵ One of the hospital's obstetricians, Hugo McVey, published a paper in 1955 entitled 'The Treatment of Disproportion by Combined Lower Segment Section with Symphysiotomy'.¹⁹⁶ In his opening summary of the procedure in Ireland and elsewhere, he notes the key concern regarding caesarean section for disproportion ('This decision, while overcoming the difficulty of the present pregnancy, makes no provision for any future pregnancy. The patient still has a contracted pelvis, and, further, a uterine scar'), and then identifies Ireland's unique obstetrical situation:

In this country we have the special circumstances of treating a population in which sterilisation and contraception are not practiced. Thus a young primigravida delivered by Caesarean section for disproportion faces a lifetime of repeat operations with all the hazards of uterine rupture, adhesions and bladder injury. In gross disproportion Caesarean section is unquestionably correct, but in minor or medium degrees of disproportion if symphysiotomy allows

¹⁹⁵ 'Clinical Report of the Rotunda Hospital for 1952', p. 27.

¹⁹⁶ *Irish Journal of Medical Science*, 1955, pp. 299-307.

of vaginal delivery on this and all other subsequent pregnancies, it is surely the operation of choice.

The paper went on to describe a series of eight 'combined' operations at the Rotunda. Because it was performed after the section and the delivery of the baby there was no measurable increase in the diameter of the pelvis, as labour had not caused the symphysis to stretch. 'No ambulatory or gynaecological difficulty was encountered' in any of the cases, and four of the women went on to have normal vaginal deliveries (the other four had not had a subsequent pregnancy by the time the paper was published). McVey proposed the combined procedure as a means of avoiding a traumatic, possibly failed, vaginal delivery in the present pregnancy (by delivering through caesarean section at an early stage), and facilitating delivery in any future pregnancy. The article is important in that it is an attempt to face the reality of successive pregnancies, and the problems of repeat sections. In one of the cases, McVey notes that the patient subsequently delivered a larger baby without difficulty, owing to the fact that the symphysis separated 'to about two fingers' breadth', and 'closed again after the child was born. No gynaecological or ambulatory disturbance occurred after delivery.'

But there is an inherent difficulty in his approach. He criticises prophylactic symphysiotomy on the grounds that disproportion cannot be determined without labour: 'It is easy to diagnose a minor degree of disproportion at 38 weeks, perform an immediate symphysiotomy and await a vaginal delivery two weeks later. If the patient then has a vaginal delivery, what has been proved? Precisely nothing. The question will still be asked: "How do you know she couldn't have had a vaginal delivery without symphysiotomy?" A question to which there is no answer, because there has been no trial of labour before symphysiotomy.' But the combined operation is in part a prophylactic procedure, as although the present delivery indicated disproportion, the next might not.¹⁹⁷ A symphysiotomy performed during labour, when moderate disproportion is proven, may be justified as a means of saving mother and child and avoiding the risk of section,

¹⁹⁷ The chances of disproportion in subsequent deliveries was high, as the numbers of repeat caesarean sections for the condition indicated.

but undertaken after delivery, almost certainly without consultation or consent, cannot.

In the same year, J.K. Feeney, Master of the Coombe Hospital, published a lengthy review of symphysiotomy, and laid down the following recommendations and conclusions:

It is said that symphysiotomy has its best application in those centres in which sterilization is not practiced after 3 or more Caesarean sections. This may be so, but the field of application should be far wider and determined by the fact that, in the well chosen case, the operation overcomes dystocia and leaves a permanently enlarged pelvis for the future; that it is safe and easy to perform and that there are no unpleasant after-effects in locomotion, pelvic instability, urinary control, etc. Let me make it clear initially that the case for symphysiotomy should be carefully selected and that the employment of the operation should not be overdone. The general indication is provided by the case of minor or moderate disproportion...Symphysiotomy has no place in the treatment of major disproportion...the most satisfactory and satisfying indication is disproportion with larger foetus in the multipara...the course of labour is on these lines: the patient advances until the cervix is as dilated as it can become under the circumstances i.e. it admits the hand or half-hand with a palpable rim all around. The presenting head is unengaged with the vertex, bearing caput, projecting into the brim. The patient is bearing down and the attendant believes that the uterus may rupture if the obstruction is not relieved. The foetus appears to be larger than previous ones. In such a case, symphysiotomy results in easy spontaneous delivery. The baby is often born within a few minutes, as the patient is recovering from the anaesthetic...I have on a few occasions rapidly performed symphysiotomy when I encountered difficulty in extracting the aftercoming head [in breech deliveries] but I do not recommend this procedure because in one's haste the

bladder might be injured. Symphysiotomy is an operation which should be performed deliberately and methodically...My experience of prophylactic symphysiotomy is limited to 7 cases which worked out satisfactorily, but I do not ordinarily recommend it. The average patient should have the benefit of a carefully supervised trial of labour...I do not present symphysiotomy mainly as an alternative to Caesarean Section. In point of fact, the indications for and scope of section have been extended in this hospital during my scope in office...At least 60 patients have returned for easy vaginal delivery after previous symphysiotomy.¹⁹⁸

Although no clinical guidelines existed for the use of symphysiotomy, there was a general consensus of opinion as to best practice, both in mid-century, and today, which exclude its use in combination with caesarean section. Our Lady of Lourdes Hospital also used symphysiotomy 'on the way out'. Of a total of 160 cases of the procedure between 1960 and 1969, 14 were symphysiotomies combined with caesarean section ('on the way out' was not used at Our Lady's after 1969, according to a statement by Connolly in the annual report for 1970-71).¹⁹⁹

Issues of Consent:

The question of patient consent to symphysiotomy in Ireland has been raised. Determining consent to symphysiotomy, or any other medical intervention, is highly problematic. It is only in recent years that written consent to elective procedures has become commonplace in Western medicine, and every responsible hospital recognises that circumstances may arise during treatment that makes the securing of consent impossible. If a patient is unconscious, in a life-threatening situation, or labouring under significant mental distress that makes consent impossible, then medical and nursing staff are placed in a position of significant responsibility with regard to the most appropriate treatment for the patient. Guidelines governing informed consent (best articulated in the case of intellectually disabled patients)

¹⁹⁸ J.K. Feeney, 'Clinical Report of the Coombe Lying-In Hospital for 1955' in *Irish Journal of Medical Science*

pp. 61-65.

¹⁹⁹ *Our Lady of Lourdes Maternity Hospital, Clinical Reports, 1960-1984.*

pertain largely to non-emergency, elective procedures, and are of comparatively recent date. Surprisingly, there is still no legal requirement in Ireland to obtain written consent to medical procedures,²⁰⁰ and outside of mental health, no clear standards for securing medical consent: 'In general, valid consent must be informed consent. The law is not clear on exactly how much information a doctor must give a patient. Consent is now legally defined for the purposes of psychiatric treatment but not for other treatment.'²⁰¹

During the period under review, consent for obstetric procedures was not sought in any coherent manner: consent was implied, and the obstetrician presumed to be working in the best interests of the patient. It is impossible to determine from this historic distance whether patients were informed when a symphysiotomy was about to be performed²⁰², or if they were made aware of potential long-term health risks. Given both the emergency conditions under which the procedure was normally conducted, as well as the hierarchial nature of medical practice in the 1950s and '60s, it is unlikely that patients were consulted to any significant degree. In this period, there were no guidelines in Britain or Ireland for obtaining consent to medical procedures, although consent was implied on voluntary admission to hospital. This situation continued well into the late twentieth century, as the controversy over the standards in paediatric care in Britain, which resulted in the Bristol Inquiry, indicated.²⁰³ This far-reaching and lengthy Inquiry investigated the care and treatment of children with cardiac illness at Bristol Royal Infirmary between 1984 and 1995. The final report was published in 2001, and represents one of the most thorough and far-reaching investigations into modern medical practice, across a wide range of issues including consent, communication, patient-doctor relationships, and responsibility. It found that even in the late 1990s, there was no formal method, or

²⁰⁰ 'Apart from certain treatments carried out under the Mental Health Act 2001, there is no legal requirement to obtain written consent, but it is generally considered good practice to make some record of the consenting process.' Medical Protection Society, *Consent to Medical Treatment in Ireland: A Guide for Clinicians* 2011.

²⁰¹ 'Consent to Medical and Surgical Procedures', The Citizen's Advice Bureau, 2010.

²⁰² In the case of symphysiotomy 'on the way out' consent was not sought as the patient was under general anaesthetic.

²⁰³ There were many key findings in the inquiry, not the least relevant of which was no. 7 in the summary report: 'It is an account of a time when there was no agreed means of assessing the quality of care. There were no standards for evaluating performance. There was confusion throughout the NHS as to who was responsible for monitoring the quality of care.' Bristol Royal Infirmary Final Report Summary, *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 - 1995* Presented to Parliament by the Secretary of State for Health by Command of Her Majesty, July 2001.

imperative, to secure patient or family consent to medical procedures. Prior to the Bristol Report, consent in Britain was vaguely defined, with the first important legal engagement with the issue of consent occurring in 1954. A case for medical negligence was taken by a patient named John Hector Bolam for injuries received during a course of Electro Convulsive Treatment, and this resulted in a landmark decision that governed standards of care for decades. Although it was originally concerned with medical negligence, it became the basis of consent in Britain for medical intervention. The original judgement determined that if a standard of care received professional peer acceptance, it was a valid course of treatment: 'It follows that if a medical practice is supported by a responsible body of peers, then the *Bolam* test is satisfied and the practitioner has met the required standard of care in law.'²⁰⁴ Once this is established, consent, especially in the mid-twentieth century, is implied.

In Ireland, the fundamental principle underpinning medical intervention is informed consent. This is supported by a series of relatively recent judgements and guidelines²⁰⁵ that stress the necessity for patient understanding of the implications of a course of treatment, and an agreement to it. Failure to secure consent (ideally in writing, although verbal agreement to a course of treatment is also valid) could potentially lead to a charge of assault against the medical staff conducting treatment. However, the area remains highly problematic, with a recognition by the courts that patients may by reason of illness, pain or stress be temporarily incapable of the cognitive understanding necessary for consent. One of the earliest relevant rulings on principles of consent was in 1965, in the case of *Ryan V Attorney General*. This case, brought over the addition of fluoride to the public water supply, resulted in an influential series of subsequent judgements regarding

...[the] constitutional right to bodily integrity in the case of *Ryan v Attorney General* [1965] IR294. What this means is that every person has the right to object to any form of bodily interference or restraint. The principle forms the legal underpinning to the concept

²⁰⁴ Ash Samanta & Jo Samanta, 'Legal Standard of Care: a shift from the traditional *Bolam* Test' in *Clinical Medicine*, Vol 3, No. 5, September/October 2003, pp. 443-6.

²⁰⁵ See the Medical Council's *A Guide to Ethical Conduct and Behaviour* (5th Edition, Dublin, 1998).

that every patient must consent to any form of medical intervention. Subsequent to this decision, it is therefore a legal requirement that consent is obtained for all aspects of medical treatment: from examination, diagnosis and treatment. In *Walsh v Family Planning Services Limited* [1992] 1 IR 496, the Supreme Court emphasises the right to bodily integrity as an important constitutional right that will give rise to an action by patients for assault or battery if a medical procedure is carried out without their consent. Such consent can be expressly given or it may be implied [Brazier, 1992]. It is possible in some scenarios to imply consent from a patient's conduct or behaviour, for example, consent can be implied by virtue of a patient holding out his or her arm for an injection. Implied consent as a valid and genuine consent is recognised by both the courts and by the medical profession.²⁰⁶

The 2008 *Fitzpatrick & Anor v K & Anor* judgement clarifies a medical practitioner's responsibilities regarding informed consent and sets out the test of capacity that should be applied.²⁰⁷ But these judgements are of limited use, and the law is necessarily non-specific with regard to consent, given the circumstances under which medical treatment may take place. Medical emergencies often require immediate action on the part of health professionals, and patients may not be in a position to provide consent. Moreover, there is a general acceptance in Irish law of the principle of implied consent, which exists by virtue of the patient attending, for example, a general practitioner for treatment. Consent, implicit or explicit, was not required for medical interventions in the 1940s and '50s, and although there was an increasing awareness of its importance after 1965, it was not legally required. Securing consent has become the norm in Ireland from the late 1990s, but is still not a legal requirement except in relation to mental health. Many branches of the

²⁰⁶ Brenda Daly, 'Patient Consent, the Anaesthetic Nurse and the Peri-operative Environment: Irish Law and Informed Consent' in *British Journal of Anaesthetic & Recovery Nursing* 2009, Vol. 10(1), p. 4.

²⁰⁷ *Fitzpatrick & Anor V K & Anor* [2008] IEHC104.

profession have put in place guidelines and recommendations in order to improve the quality of patient care, but these are not legally binding.²⁰⁸

Draft Report Summary:

The use of symphysiotomy from the mid 1940s to approximately 1965 was a specific response to exceptional Irish circumstances. An extraordinarily high fertility rate combined with a ban on artificial contraception meant that married Irishwomen faced multiple pregnancies in swift succession. The hospital maternal mortality rate had fallen dramatically by the 1940s, and Irish post-war obstetricians, in common with their British counterparts, became increasingly interventionist in labour. However, they faced particular problems that differed from the UK. An Irish mother with contracted pelvis did not have the option of limiting her family through artificial contraception, in the manner that was legally possible for her British counterpart. Although many in the medical profession deplored the circumstances surrounding incessant pregnancy and delivery, they, along with their patients, were constrained by a rigid system that took little account of the often intolerable physical, emotional and financial strain that large numbers of children placed upon families. The legal restrictions regarding family limitation options ensured that symphysiotomy was explored as a means of addressing obstructed labour, in an era when the relative safety of repeat caesarean sections was unproven, and sections carried a high mortality and morbidity rate. This is the context in which symphysiotomy reappeared in Irish obstetrics. It was always a controversial development. Although some obstetricians heralded it as a solution to a wide range of difficulties in labour, others refused to contemplate it because of fears of both short and long-term consequences including incontinence and pelvic instability. These reservations are reflected in the fact that even when use of the procedure was at its height in the mid 1950s, it remained a rare event relative to overall deliveries, and was never utilised in all maternity hospitals throughout the country. In cases of mild to moderate disproportion, leading to obstructed delivery, symphysiotomy was an appropriate clinical response.

²⁰⁸ AIMS (Association for the Improvement in Maternity services) Ireland is working with HIQA (the Health Information and Quality Authority) to draw up guidelines for the improvement of maternity services, which will have consent to medical procedures and treatment at its core.

Symphysiotomy began to decline from the late 1950s. The period marked significant advances in maternity care and maternal health, and saw an increasing use of caesarean section to deal with obstructed labour, the main indication for symphysiotomy. As the safety of repeat sections became clear, their numbers increased steadily, and symphysiotomies declined. However, Our Lady of Lourdes Hospital in Drogheda continued to use the procedure until 1984, almost twenty years after it had largely ceased elsewhere in Ireland. The other area of concern is the use of symphysiotomy immediately after caesarean section, which is not recognised as good practice in the past or present.

Findings:

- Symphysiotomy was reintroduced in certain Irish hospitals in the 1940s, and was a clinical response to the legal limitations on contraception, and sterilisation for contraceptive purposes. This restrictive legislation reflected a predominantly Catholic religious ethos, which determined that contraception and sterilisation for the prevention of pregnancy was both illegal and unacceptable. Its use reflected the fact that in the 1940s and '50s the safety of repeat caesarean sections was unproven.
- It was used in the majority of cases as a response to obstructed labour, in women suffering from mild to moderate disproportion, and as such was regarded as a clinically appropriate decision.
- It was never proposed as an alternative to caesarean section, rates of which rose steadily in the 1950s and '60s.
- It was a safer intervention in cases of mild to moderate disproportion, with a minimal maternal mortality rate, and a lower foetal mortality rate, than caesarean section.
- It was an exceptional intervention, used on average in 0.36% of deliveries in the Coombe and National Maternity Hospitals, where the usage was highest.
- Its use was continually evaluated and debated, and declined as maternal health, and caesarean delivery safety rates, improved.

- It appears to have been inappropriately used in a number of cases. These relate to 'symphysiotomy on the way out', when it was performed after delivery, while the mother was being stitched following caesarean section.
- The persistence of the procedure at Our Lady of Lourdes Hospital, Drogheda until 1984 runs contrary to its decline elsewhere in the country from the mid-1960s.

Section Two: Results of Consultation Process

Final Symphysiotomy Report.

This final report on the practice of symphysiotomy in twentieth-century Ireland includes the principal elements of the earlier draft report, originally released in June 2012, with amendments and additions made as a result of the consultation process held between June and September 2012. The report was revised and submitted on April 7, 2013 and immediately sent out for anonymous peer-review, in line with good academic practice.

The public consultation process consisted of meetings held at a number of locations nationally, as well as the collection of written submissions by email and post. A wide range of individuals responded to the consultation phase, including survivors of the procedure, obstetricians and nurses who had performed it and were involved in follow-up care, the husbands and children of survivors, and other individuals who offered considered responses to the work. Each response to the draft report, and the recital of the experience of symphysiotomy and its aftermath, was unique. I would like to record my deep gratitude to all who so generously took part in the consultation, and who took time to write with their responses and reflections. I am aware that this is a difficult topic for many, and I have been struck throughout by the consideration shown by participants, and the thoughtful responses made. I would like to thank in particular the women and their families who in many cases travelled significant distances to attend the consultations, and took part so willingly in discussions.

The written responses to the Draft Report, which were submitted from all over the country, are an invaluable part of this Final Report, and I very much appreciate the time and effort spent in compiling them, given that many found it difficult to raise often distressing memories. The families of survivors played a vital part in the formulation of the Final Report, and I would like to thank in particular the children (many of them born as a result of symphysiotomy) and husbands who came to the meetings, and submitted their own experiences of the consequences of the procedure. Daughters, sons and daughters-in-law took on the role of scribes, and helped with the submission of responses by post and email. I would also like to express my gratitude to the health professionals who responded to the Draft Report,

offering their experiences from the hospital and nursing perspectives, their reflections on the use of the procedure during their working lives, and their comments on the social, political and religious context in which they worked. I am grateful to the hospital administrators all over the country who clarified and checked historic returns for me in relation to symphysiotomy usage in their institutions. My thanks, too, to the contribution of the independent patient advocacy group, Patient Focus, whose assistance in updating and supporting survivors throughout the consultation process was invaluable. Their efforts, along with those of Survivors of Symphysiotomy Ltd, ensured that the survivors' voices were clearly heard throughout the consultations, and that the process maintained its vital independence from vested interests throughout. Special thanks in this regard are due to Olivia Kearney and Kathleen Naughton, founder members of Survivors of Symphysiotomy in 2002. They have worked consistently for the past decade to support the women, and continue to play a central role along with Survivors of Symphysiotomy Limited, formed in 2011 under the Chairmanship of Tom Moran. The media played an important part in raising the issue years before the Draft Report, and some local media outlets, radio in particular, worked hard to prevent the exclusion of participants in the process, and to disseminate accurate information about the consultation and its objectives. Finally, I am very grateful to the three anonymous peer-reviewers, whose insightful comments helped to ensure clarity in this Report.

This Final Report is the second stage of a two-stage process. The first was the compilation of the Draft Report, a research project that sought to establish the rates of usage of the procedure in Ireland, the environment in which it was revived, the medical literature that discussed its usage here and in the developing world, and the reasons behind its decline. This permitted the establishment of an academic baseline for the appraisal of the procedure, and was undertaken as an independent research study, free from the influence of any vested interest. The second phase was a consultative study, that invited responses to the Draft Report, and both incorporated any necessary amendments and clarifications to the Draft element, and presented the results of the second, consultative phase. When the Draft Report was released, a public consultation process was undertaken for two key purposes: the first was to discuss the Report with survivors, and provide opportunities for feedback to it, and to facilitate the submission of personal accounts of patient and practitioner

experiences. The second was to allow for responses to the Draft Report from any interested party, through written submissions by email to a dedicated confidential address. The consultation process was designed to permit the widest opportunity for those concerned to engage with the report. There were three large-scale face-to-face meetings, and a small number of individual meetings with women and their families who were unable to attend the main sessions, or who did not wish to attend a group meeting.

The public meetings were as follows:

Clarion Hotel, Cork:	4 th July
West Court Hotel, Drogheda	5 th July
Aisling Hotel, Dublin	13 th July

One of the unexpected but useful results of the consultation was the fact that some women who had undergone the procedure and were not affiliated to any support group, nor had sought previously assistance or evaluation from the HSE, now came forward, and through the regional Liaison Officers were offered support for any health issues they believed were associated with their symphysiotomy.

91 people attended the public and individual meetings, and consisted of women who had undergone the procedure, their husbands and children, and health professionals. 101 written submissions were made by post and email, and included all of the above, as well as submissions from public representatives (there were responses from elected representatives from each of the major political parties, confirming cross-party concern for the outcome of the Report) and members of the public. There was a wide geographical spread, but the highest levels of representation came from the Dublin area, and the North-East, a fact that reflects the higher use of the procedure in the Dublin maternity hospitals, and the persistence of symphysiotomy in Our Lady of Lourdes Hospital, Drogheda, when it had largely ceased to be performed elsewhere in the country.

Key Responses to the Draft Report:

1. Why Symphysiotomy?

Perhaps the most pressing, and indeed the most obvious, response to the Draft Report was the question of why the procedure was performed in each individual case. I did not look at personal medical records for this study (it was beyond the terms of reference, and was also not ethically responsible from my perspective), but women repeatedly asked this question in person and in writing. Many noted that they could not understand the necessity for the operation: those who were second and third-time mothers, with normal pregnancies leading up to the symphysiotomy, worried that they had done something wrong which led to the procedure. In the course of discussion some survivors indicated that they had had difficulties in the course of labour which may have led the obstetrician to feel that a symphysiotomy was appropriate. However in the absence of any explanation at the time, they are now left in the difficult position of speculating why they were selected for the procedure when other mothers, who seemed to have similar pregnancies and circumstances, were not. At each consultation mothers (and also daughters) requested the possibility of a confidential discussion with a sympathetic obstetrician, midwife, or other health professional, who could look at medical notes where available and explain the context for symphysiotomy in both general and particular terms. Given the wish of the Institute for Obstetricians and Gynaecologists to help, they could play an important role in facilitation.

2. Malnutrition:

This issue was raised repeatedly throughout the consultation process, and refers to the section of the Draft Report which set the social and economic context for the reintroduction of symphysiotomy (pages 33-37 of original Draft Report). It reported that many mothers in the Dublin hospitals (and the Coombe in particular) presented for delivery in poor health. Many were suffering from malnutrition and chronic illness associated with poor diet and living conditions. This evidence was contained in the Dublin maternity hospital reports, in the 2009 Ryan Report, and the accounts of medical staff at the hospitals from the 1930s to the 1950s. However, this was in no way to suggest that the present survivors were themselves malnourished or from deprived backgrounds, and I sincerely apologise for any unintended hurt that this may have caused. The environment of the 'hungry thirties' was very

different from that in which most respondents were raised, and their nutritional and general circumstances far better.

However, the physical health of mothers in Dublin in particular had a crucial role to play in the reintroduction of symphysiotomy in Ireland, which is why the issue is so important: obstetricians were used to dealing with some women whose physical condition made medical intervention much more likely, and symphysiotomy was part of that intervention. One respondent who trained at the Coombe in the 1960s remembered the general environment well:

In 1964...I had the privilege of doing my rotation in O and G²⁰⁹ in the Old Coombe. I was one of the last groups of students there. I say “privilege”, because nothing in my upbringing or education had prepared me for how dreadful it was. There was real poverty. Many women had none of the basic facilities for themselves or their babies; clothing, underwear, blankets etc. Many looked pale and malnourished. Profound and chronic anaemia was commonplace. There was no lift in the building and the labour ward was on the third floor. Even worse was the “district”. This was the domiciliary practice where women were attended in their own homes. The degradation was terrible. Much help was given by the Hospital Almoners, the Voluntary Linen Guild and indeed Guinness’s Brewery. A decade or two previously it was probably much worse.

As this respondent later notes, ‘Things did improve in the mid ’60s with the advent of the new Coombe Hospital with better equipment and with a general improvement in economic conditions.’

3. Accuracy of Published Figures for Symphysiotomy:

The figures used in the Draft Report were those available in the published annual reports of the Rotunda, Coombe and National Maternity Hospitals, Dublin, Our Lady of Lourdes Hospital, Drogheda, and the Cork Maternity Hospitals. It also included verified figures from other regional maternity hospitals including those in counties Galway, Donegal, Limerick, Sligo, Mayo, Wexford, Waterford and others. The Terms of Reference for this Report excluded the examination of individual primary medical records, and the examination of these nationally would require the appointment of a large dedicated research team to hand-search the historic records of each maternity hospital. Some of these records are no longer available, and others

²⁰⁹ Obstetrics and Gynaecology.

are in storage, and would require patient permission to access. The consultation process indicated that there was one inaccuracy in the published data of the Dublin maternity hospitals, another single procedure in Limerick, and discrepancies in the published figures for Cork. These issues are complicated by the fact that several hospitals have merged, or are no longer functioning as maternity units. However, this small number aside, the figures in the Draft Report are reflective of the actual number of procedures performed. The numbers of women associated with the various support groups, as well as those who have been evaluated by the HSE as part of their dedicated system of support, indicates the accuracy of the rates.

4. Use of Procedure in Emergency Deliveries:

There was some misunderstanding of the use of the term 'emergency' in the context of symphysiotomy, which requires clarification. Several respondents wrote that they were not emergency deliveries, in that they were not rushed to theatre in an immediate life-threatening situation. However, many were in situations where they had been in labour for long periods of time (four recorded that they had been in labour for three days), and were not delivering naturally. In the Draft Report women in delayed, suspended or non-progressing labour were included as emergency deliveries, in that they were unlikely to be able to deliver without medical intervention, and there was significant danger to their babies unless labour was concluded. When symphysiotomy was reintroduced, Arthur Barry recommended it specifically in cases where labour had not progressed, and the baby's head had not engaged. A symphysiotomy often allowed the head to descend, and in many cases the baby was delivered within one or two hours of the procedure being performed. This is not to argue that there should be no challenge or criticism of symphysiotomy in these cases, but to state that in the 1950s and 1960s these cases were regarded as medically suitable for the procedure.

As was noted in the Draft Report, one of the key indications for symphysiotomy was cephalopelvic disproportion, and contracted pelvis. There was widespread acceptance of this diagnosis, by British and Irish obstetricians alike. However as was also noted in the Draft Report, the use of oxytocin to accelerate labour, combined with better nutrition, virtually eliminated the need for symphysiotomy. The 'Active Management of Labour',

an approach developed in the National Maternity Hospital, had the enormously beneficial effect of avoiding ‘the physical and emotional trauma of labour’, and revealed that many cases of what had previously been considered cephalopelvic disproportion were in reality inefficient uterine action:

On a historical note, it was in the National Maternity hospital that the operation of symphysiotomy was revived in the 1940s, to offset the commitment to repeat caesarian sections in young mothers with a diagnosis of cephalopelvic disproportion. This practice continued for more than 20 years until active management of labour was introduced in the 1960s. This development ensured efficient uterine action for every nulliparous woman in labour. Soon it became apparent that most women previously treated by symphysiotomy, or caesarian section, after failed trial of labour suffered not from cephalopelvic disproportion, but from inefficient uterine action. Within a few years the recorded incidence of cephalopelvic disproportion had fallen to a small fraction of the previous level.²¹⁰

5. Caesarean Section:

There were repeated claims that the sections of the Draft Report that dealt with the relative safety of caesarean section were inaccurate, and assertions that the absolute safety of repeat caesarean section was proven from the 1930s. Without merely repeating the literature and arguments from the Draft Report it is necessary to say that this is untrue. Irish obstetricians were trained, as were their Western-educated colleagues, to the so-called ‘3 caesar’ rule, and believed in the saying ‘once a caesar, always a caesar’. Until declining maternal mortality rates showed the relative safety of repeat sections in the 1960s (owing to improvements in anaesthesia, better maternal health, the widespread use of the safer lower uterine segment section, more reliable blood transfusions, and the general availability of antibiotics), there was a significant degree of danger associated with caesarean section. In Britain, it became increasingly common to perform several sections, and then advise the mother to be sterilised, or to use artificial contraceptives. This was not an option in Ireland. Thus symphysiotomy was revived in the context of a high level of conformity to Catholic doctrine regarding contraception, and the

²¹⁰ K. O’Driscoll, D. Meagher & M. Robson, *Active Management of Labour*, 4th Edition (London, 2004), p. 64.

expectation that a young married woman would be likely to have a large family. Caesarean section was and remains a major operation, and its alarming rise world-wide is a cause of great concern, carrying as it does a significantly raised mortality rate in comparison with natural delivery.

This table is a summary of the relative outcomes of caesarean section Versus symphysiotomy in the three Dublin maternity hospitals – see pages 21 to 24 of Draft Report for full annual returns:

Maternal and Fetal Death Summary, Dublin Maternity Hospitals²¹¹

	Symph	Mat death	Fetal death	CS	Mat death	Fetal death
Coombe	212	0	16	1661	9	126
Nat Maternity ²¹²	250	0	22	1351	9	114
Rotunda ²¹²	17	0	0	1879	17	160
Total	479	0	38	4891	35	400

6. Pubiotomy and Craniotomy:

Several respondents raised the issue of other rare interventions in deliveries, and asked the question of whether the rates of symphysiotomy needed to be adjusted in relation to pubiotomy and craniotomy in particular.²¹³ Neither procedure was within the terms of reference of this Report, and although both were associated with very difficult labours, they were extremely rare. Some survivors have suggested that they underwent a pubiotomy (the separation of the pubic bone, performed to increase the capacity of the pelvis to permit passage of a fetus), as opposed to a symphysiotomy: confirmation of this would require the examination of individual medical records, which is not possible in this Report, although it is obviously a key issue for clarification in these cases. Craniotomy (a procedure rarely used in the case of the deceased baby of a mother with contracted pelvis: the foetal skull was

²¹¹ My thanks to the anonymous peer-reviewer who suggested this summary table.

²¹² Most of these symphysiotomies were combined with caesarean section and not undertaken during labour.

²¹³ My thanks to the respondents who raised these issues.

collapsed to allow for delivery) did not arise in any account linked with this Report, nor was it part of any survivor's experience.

7. Misrepresentation of Draft Findings:

There were serious misrepresentations of aspects of the Draft Report that caused substantial anxiety to survivors. Not least was the frequently reiterated untruth that the Report stated that 97% of the procedures were appropriate. At no point does this statistic ever appear in the Draft Report, nor was any such statement made anywhere in the report. Frequently stated, and reproduced without query by elements of the media, this did little to help survivors, many of whom were greatly distressed as a result.

Some reporters and commentators read the Draft Report, and engaged fairly with its findings: the purpose of the release of the Draft was precisely to allow for criticism and revision. Others, however, displayed a reckless irresponsibility, preferring to sensationalise coverage rather than look beyond dramatic headlines to assist in the resolution of the issues. Indeed, several journalists made specific representations on the Report, and sought responses to provocative statements, while casually revealing that they had not in fact read it. Survivors have indicated the important role the media, especially local media, have played in helping to keep the issue to the forefront of the political agenda. It is regretful that many opted for a rather easier, and less rigorous path.

8. Role of Religion:

Three obstetricians who practiced throughout this era confirmed the power of Catholic doctrine in obstetrical practice (one in Dublin and two in regional hospitals). Two indicated that there were frequent clashes with Catholic Boards of hospitals, when issues relating to sterilisation and contraception came before them for discussion. They also reported that many mothers themselves were very conservative in their beliefs. They regarded contraception as anathema, and would not accept advice as to family limitation, even when their health was endangered through complications relating to pregnancy. Thus it is important to note that although symphysiotomy's revival took place in the context of a rigid Catholic Church stance on contraception, it was a value system accepted willingly by lay people. 'There has been repeated reference to the fact that artificial methods

of contraception were condemned by the Catholic Church and were also illegal. In addition it should also be stressed that the large majority of women, especially in rural areas, were unwilling to go against the church's teaching and so were likely to have a large number of pregnancies.'²¹⁴

Responses to the Consultation Process:

There are lessons to be learned from the manner in which a topic such as symphysiotomy is handled in the press and other public fora. At each of the consultation meetings survivors indicated their discomfort at the manner in which, as one expressed it, the topic had been 'hijacked' for personal and political ends²¹⁵, and grave concerns were expressed over the confrontational nature of the coverage. Nine respondents indicated that they were deeply uncomfortable with the continual presentation of the women as victims, and were unhappy with the demonization of the medical profession as a whole. 'I wish it hadn't happened to me, as it has limited aspects of my life. But it was done in my case because the baby was stuck, and he was born safely thank God. My own mother suffered all her life from back pain, incontinence, and mobility problems because of her seven 'natural' deliveries so I know it takes a toll on the body even when there is no medical intervention. It angers me to be called a 'survivor' and a 'victim' when I am none of these things.'²¹⁶ A Dublin mother pointed out: 'It's pointless to look for an apology from any doctor today, if they didn't do a symphysiotomy themselves. They've apologised on TV and said it wouldn't happen now and I don't believe in my case anyway that it was done for any reason other than to bring the baby out quickly. Lots of things were done in the past that turned out to be wrong I suppose but you can't blame a whole profession for the actions of a few. I don't believe that they deliberately set out to do harm.' While acknowledging in five of their own cases that there had been mismanagement of their care immediately after their deliveries, this group indicated that they had enjoyed good quality treatment from other obstetricians and GPs that had substantially eased the physical problems they faced. They were distressed that a complex and difficult issue had been reduced to point-scoring, and felt excluded

²¹⁴ Respondent practising in the 1970s, '80s and '90s.

²¹⁵ Attendee at the July 5th meeting at the West Court Hotel, Drogheda.

²¹⁶ Delivery in 1967.

from a public discourse that viewed them in a rigid and simplistic manner. They noted that this was unhelpful and unfair to the campaign as a whole, as well as exacerbating the specific problems they faced.

Key Points Made by Respondents:

It should be noted that this section of the report is based upon the statements made by respondents in person and through written submissions, and represents personal narratives regarding experiences of symphysiotomy. In the absence of a robust clinical study of the procedure in Ireland, it is difficult to determine the extent to which some of the adverse outcomes stemmed from the complicated deliveries in which the procedure was used. Amongst the responses to the consultation were women who reported significant chronic illness following traumatic deliveries in which symphysiotomy was not employed (see below), and back pain, urinary incontinence, and other complications are of course common following 'natural' deliveries, and in women with several pregnancies and deliveries: many of the women at the consultations raised this issue in discussion. However, although every response to the process was personal and individual, many accounts had common themes which are discussed below, and which include consistent reports of symptoms including mobility problems, issues with continence, and chronic pain. As all contributions were made in confidence any responses cited or referred to in this Report have been anonymised, with the year of delivery noted as the means of distinguishing between cases. The majority of the procedures were performed on respondents between 1960 and 1972, with a small number dating from the 1950s. Although this is in the relatively recent past, it represents a different era in terms of the information provided to patients, and the understanding of the importance of good communication between practitioners and patients. There has been an increasing recognition of the role that knowledge, and informed consent, makes to patient satisfaction in medical engagements, and indeed the impact this can have upon recovery rates. However, at the time that the majority of these procedures were performed there was little recognition of the importance of involving patients in the routine discussion of their care, and decisions regarding methods of delivery lay largely in the hands of obstetricians who made them on the basis of what they judged to be the best outcome for mother and child. There was an overwhelming culture of deference that militated against patient engagement: this was of course

reflective of a general culture in this period, and was equally prevalent in Britain as in Ireland. One respondent, a retired practitioner, pointed out that it was not exclusively the result of an excessively high regard, but a mutual acceptance of expertise and authority. In relation to 'the lack of communication with the patients and the lack of obtaining informed consent...It may seem amazing today but it is difficult now to realize the extent to which 'authority' was accepted not only in all forms of medicine but in all walks of life. The doctor took it as his duty as the 'expert' to make the necessary decisions and in general the patient expected this.' There were additional factors in the Irish case that tended to ensure that some professionals were not merely respected, but venerated. Several respondents who had undergone symphysiotomies at Our Lady of Lourdes Hospital were told by the nursing staff that Dr Connolly's hands had been 'blessed by the Pope' and they were therefore fortunate to be in his care. The possibility that patients would question his treatment, and that of others, was remote.

'Now I wonder why I didn't speak out but in those days one didn't question authority and more so a doctor!'²¹⁷ '...we just trusted them and well if it has to be done it has to be done. You didn't say is there an alternative way or anything...people didn't ask questions of doctors. They were Gods. It would have been so unusual to ask questions.'²¹⁸

By far the greatest sense of disquiet related to the lack of knowledge regarding symphysiotomy. There was deep sense of anxiety linking many of the women's accounts, relating to the question of why the procedure had been used in their particular case. There exists a strong and widely held feeling that an explanation for why a symphysiotomy had been performed would have made a great deal of difference in adjusting to the after-effects (see outcomes below). At the public meetings, and through written submissions, the women repeatedly returned to the issue. Despite the fact that the after-effects impacted significantly upon the quality of their lives, there was nevertheless a strong and frequently reiterated sense that if the decision to perform the procedure had been taken in good faith (i.e. for the safety and health of the baby and mother), and explained as such, the subsequent adjustment to the physical and psychological problems would have been

²¹⁷ Delivery in 1970.

²¹⁸ Jillsen, *Symphysiotom*, pp 19-20.

substantially eased. In the absence of any medical explanation, it is all too easy to present symphysiotomy as a random assault upon the person. The fact that it is part of a process which should by its nature be positive and joyful placed an additional burden upon these women and their families: 'I used to be always looking at friends who had their baby at the same time and wondering what was wrong with me, that I couldn't just get better and get on with things.'²¹⁹ 'I hadn't a clue what to expect. All I knew was that if this is what having a baby is like, I didn't know how anyone ever had more than one.'²²⁰ Without exception, the respondents wished that their experiences would be used to underpin changes in the Irish health care system that would ensure that patients are fully informed of the reasons justifying any intervention, their consent secured, and the consequences explained.

The system is moving in this direction. In May 2008 the HSE launched the National Strategy on Service User Involvement, which seeks to improve communication, response and outcomes for a range of health service users.²²¹ In an ideal world, all interventions would be discussed and agreed with patients in advance, but the nature of illness and injury is such that this is not always possible, and in a stressful situation a patient may take in little of what is being said. But effective follow-up discussion, in terms of the explanation of the use of a procedure such as symphysiotomy, would have made an enormous difference to many of the mothers. At the consultations, and in writing, over half of the respondents asked why the procedure had been used in their case, and an attempt to do this, even many decades after the event, could certainly be helpful to some: this might be considered by the HSE.

In an era that places much more emphasis upon patient-centred care, it is difficult to comprehend the dynamics that routinely underpinned an older system of medical practice. Fifty years ago and more, hospital care operated under a strictly timetabled regimen in which the consultant was supreme. Patients were rather more a collection of ailments and injuries to be treated to the best of their ability, than partners in a system of negotiated treatment. This philosophy underpinned western medical practice in general, and was not specific to maternity care: it was a common

²¹⁹ Delivery in 1971.

²²⁰ Delivery in 1969.

²²¹ <http://www.hse.ie/eng/services/ysys/SUI/Library/strategy/update0909.html>

occurrence for surgeons to discuss cases literally over the bed of a patient with medical students without acknowledging the person in it. There was an acceptance of the concept that a doctor, particularly a consultant, knew best – their extensive training equipped them for diagnosis and treatment, and a brisk professional attitude reflected their own confidence in their ability to cure. Some women's testimony reflects this attitude, and the respect with which their obstetricians were regarded made even the formulation of a criticism of their treatment difficult. 'I thought it just must be me. Dr [--] was spoken so highly of by everyone, and I liked him too. He was always known as a man dedicated to his profession.'²²² 'I was in the delivery room, and Dr [--] came and put his hand on my arm and said 'Now Mrs. [--], we're going to have that baby out for you in two ticks! I felt very safe with him.'²²³

Outcome from Symphysiotomy:

There is a direct correlation between the levels of explanation and discussion of the procedure and its consequences by healthcare staff, and respondents' own evaluations of the outcome. Without exception, the most favourable were recorded in those cases where either the symphysiotomy had been discussed with the obstetrician beforehand, or when the women were told what the procedure was, and why it had been used in their cases. This occurred for eight of the respondents, and although five of that group reported long-term mild to moderate side effects – 'I was in the hospital for about 2 weeks with catheter. I could walk a little after about 2 weeks. Dr [---] explained symphysiotomy to me some time before the surgery. He was very kind and I thought highly of him...I have some medical problems including frequent lower backache. I cope well now, with daily exercises' - they regarded the overall outcome as positive. They felt that they were generally well informed, and they understood why the symphysiotomy had been undertaken. Several of this group used the term 'trust' in relation to their obstetrician, and this confidence is reflected in their experiences. These women also indicated that they had discussed their cases with their doctors, and this level of communication placed them in a position where they felt in control of the process. The overwhelmingly negative experiences of the procedure that are in the public domain do not reflect their cases: 'One of the reasons I had hesitated to speak of my experience publicly before now was that I felt

²²² Delivery in 1973.

²²³ Delivery in 1977.

I could have no part in looking for any kind of redress since I had only a positive experience. Also Catholic teaching played no part in our decision to opt for the procedure. I was also aware, despite my innocence about what the baby's head should be doing, of the possible disadvantage of a caesarean section and was very glad to be able to avoid this.'²²⁴ Another spoke of periodic difficulties with continence – 'I had some urinary incontinence problems for about a year after the delivery, which resolved itself. I now have some minor problems in that area but it's my age now I suppose.'²²⁵ One Louth mother stated that 'I find it difficult to talk about my symphysiotomy as I have not had any problems as a result of it. Dr [--] had advised me that I needed to be careful after the delivery and I have to say that the nurses were excellent. They kept me wrapped tightly in bed and helped me to walk about two weeks after my baby was born. For me the experience was good as was my next delivery.'²²⁶ A mother from Dublin stated: 'I feel sorry for some of the women who had such bad experiences. They say that they can remember being cut apart and that is very distressing as that wasn't at all what my operation was like. I had my symphysiotomy during the birth of my first child, and the doctor used local anaesthetic. I didn't feel anything, and I recovered with no more problems than after the births of my subsequent two.'²²⁷

By contrast, the respondents who reported the worst outcomes were those who had not been consulted in advance, nor informed after their deliveries that a symphysiotomy had been performed. Almost 20% of the respondents stated that they had not been told that a symphysiotomy had been undertaken: these women also reported the poorest outcomes overall. There is an obvious conclusion to be drawn in that a lack of information on the procedure made a great difference to long-term outcomes. These new mothers could not understand why their recovery was different from that of other women, and they were in many cases reluctant to discuss the issue as they felt they ought to simply improve. One woman noted that 'I had no one to talk to...my own mother had never had medical intervention so she thought it was shameful and told me not to be telling anyone about it.'²²⁸ The greatest

²²⁴ Delivery in 1962.

²²⁵ Delivery in 1968.

²²⁶ Delivery in 1964.

²²⁷ Delivery in 1963.

²²⁸ Delivery in mid 1950s.

difference between the two groups was the aftercare they received: this experience not only coloured their stay while in hospital – ‘I would have done anything at all so I could get out of there. When they asked me if I felt any pain I said ‘no’ in case they’d keep me in’²²⁹ – but the mismanagement of their physical needs caused many long-term health problems. The women who were adequately bound, given bed rest and pain relief, and allowed to gradually become mobile after delivery, reported the best immediate and long-term outcomes from symphysiotomy (see aftercare below).

There were many cases in which women were told that some kind of procedure was about to be performed, but were not told what it was, or what the long-term outcome might be. In some cases this was in the context of an emergency delivery. Three of the respondents indicated that they could not remember whether they were told they were about to have a symphysiotomy, an understandable position in the context of a stressful labour: ‘I think the nurse told me the doctor was going to do something to make the baby come quickly, but I don’t remember if she said it was a symphysiotomy. I wouldn’t have known what she was talking about if she did. I’m sure I never heard the word until five years ago, when I found I had had one.’²³⁰ One mother ‘was told there was a problem that the baby’s head was very big and they were doing a procedure on me to get the baby out fast. I was very scared because nobody explained to me fully what they were about to do...I remember the Sister saying to me to be quiet. Her words were “For goodness sake would you be quiet. We are doing this to get your baby out fast.”’²³¹ In others it was presented as a means of easing the birth. ‘I was told “you are going to have a little procedure to make it easier for the baby to come through.”’²³² A mother who delivered in Dublin in 1966 had her symphysiotomy before labour: ‘At the time I was told that I would have to undergo “a simple little procedure” to ensure that my baby would survive the ordeal of a natural birth.’ In the middle of a prolonged and difficult delivery a mother in Drogheda was told by the obstetrician that ‘the baby’s head had moved – the face was coming first and he would have to perform a symphysiotomy on me. He

²²⁹ Delivery in 1971.

²³⁰ Delivery in 1976.

²³¹ Delivery in 1979.

²³² Delivery in 1970.

explained what he was going to do and I would have no trouble having more babies.’²³³

Many respondents indicated that the negative impact was exacerbated by the fact that they were not consulted before, or informed afterwards. Many acknowledged that the procedure may well have been done with the best of intentions, but were bewildered and angered by the fact that they did not have any opportunity to discuss what had happened: ‘Whether their reasons were religious or for training benefit or their genuine belief that it was the safer option it was their total disregard and failure to consult with me either before or after that I as a survivor of symphysiotomy find most insulting and warranting explanation and recourse.’²³⁴ It would have made a great deal of difference to the women’s state of mind, and indeed their sense of self, to have had the symphysiotomy explained to them. Although delivery notes record its use, given their nature they do not provide any discursive detail on the decision to perform the procedure. This means that even when mothers have access to their medical records, they have little context as to the decision to use a symphysiotomy.

Aftercare:

There was a wide divergence in the standard of aftercare, which impacted significantly upon long-term health outcomes. When symphysiotomy was revived in mid-twentieth century Ireland, Arthur Barry outlined the basic standard of care required. Recommending the use of a ‘belt’ (a surgical corset) during delivery, he wrote: ‘The symphysiotomy belt may be tightened up firmly when labour has been completed, so that the patient may gain full benefit from its support. The belt is usually discarded in five or six days. The patient is allowed up on the tenth or eleventh day. No special corset or pelvic support is required unless the individual feels the necessity of it herself. Full painless locomotion will have returned within four to six weeks, often much earlier. Heavy weights should not be lifted for three months.’²³⁵ He went on to detail the range of side-effects, and the manner in which they should be managed. Thus from the 1950s information on good practice was available, and the importance of bed rest commonly known. Binding the pelvis was intended to permit the joint to heal, and was the principal purpose behind bed rest

²³³ Delivery in 1971.

²³⁴ Delivery in 1972.

²³⁵ Barry, ‘Symphysiotomy or Pubiotomy’, p. 53.

and immobilisation. However, many respondents noted that they were told by nursing staff to get out of bed and begin to walk within a day or so after delivery. Several of these state that they were not bound,²³⁶ nor had any sort of support girdle or corset immediately after the procedure. Given that the fibres holding the pelvis together had been partially severed, and the pelvis was therefore rendered unstable and weakened, standing, and especially walking, could potentially lead to much greater damage. Instructing a newly delivered mother who had just undergone a symphysiotomy to walk without support is an incomprehensible failure in duty of care. The resulting instability led to serious long-term side effects for some women, and even to the incorrect fusion of the pelvis, leaving individuals with chronic pain and locomotion problems. Despite the fact that many respondents delivered in the same maternity unit, their accounts varied widely in terms of postoperative care. Irene Jillson's recent study of 29 symphysiotomy patients also found a variety of treatments and advice to mothers as how to deal with the aftermath of the procedure.

Notwithstanding the fact that there were known protocols for how to help ensure that women who had a symphysiotomy would heal most effectively and as quickly as possible, these protocols were not usually and not consistently followed. Women were told to use a pillow to splint while coughing, most were not bound, some were told to stay sitting, others to lie down, at least one was forced to walk right away, and one reported being made to walk up and down stairs in the stairwell at the hospital in heels at a follow up visit.²³⁷

Indeed, several women treated in the same hospital reported entirely different aftercare. One was told by a nurse to get out of bed the day after her procedure, and was asked to walk up and down stairs three days after the delivery. Other women in the same hospital were confined to bed for periods of up to two weeks, and discharged four weeks after delivery.²³⁸ Similarly respondents report differing advice from the same obstetrician: one woman was bound firmly at both pelvis and ankles to minimise movement, while another was not bound, and given no assistance or

²³⁶ Most women were either bandaged tightly around the pelvis after delivery (to offer support to the pelvis) or (less commonly) were placed into a pelvic corset and advised to lie as still as possible on their backs.

²³⁷ Irene Anne Jillson, *Symphysiotomy in Ireland: A Qualitative Study* November, 2012, p. 12

²³⁸ Delivery in 1952.

advice in changing position in the hospital bed. The contradictory approaches could cause significant distress. In 1966 one mother found herself caught between two nurses: 'The second day after the birth a nurse came up to my bed and told me to get out as she wanted to make the bed. I told her I was not to get out of bed for five days. She asked me did I think I was in a hotel, at this stage she almost threw me out then she saw the bandages and threw me back in again. As you can understand I was crying and very upset at this stage. A little later a nun came in. She said had I stood up, I would never walk properly again.'

A common theme in the women's accounts was a style of nursing that was brusque, to the point of pain. A great deal of emphasis during labour was placed by nurses upon delivering 'naturally', meaning the avoidance of caesarean section as opposed to forceps or any other intervention. It also meant avoiding 'bothering' the obstetrician. When one mother pleaded with a nurse to call the doctor because she was in such distress, and believed that something was wrong, she was told to 'Keep pushing: Dr [--] hates to be called at night.' Many nurses appeared to operate on the basis that patients were neither consulted about their condition, nor believed when they reported pain. There was a cheerful disregard to complaints, but more distressingly a determination to push women into movement before they were ready, which had serious consequences for women who were unbound and unsupported after symphysiotomy. This apparently stemmed from an adherence to standard nursing practice of mobilisation within days after delivery, which while good practice in the case of women who delivered normally, caused pain and damage in several cases. It would appear that some nurses were not advised of appropriate care in symphysiotomy cases, and even when some had been told of the need for binding and immobilisation, their colleagues on other shifts had not. Three of the respondents recalled that it was only the intervention of other patients in the maternity ward, who called out that the woman had had surgery, which alerted the newly-arrived nurse to the necessity for immobility.

This is not for a moment to apportion blame to nurses for negative outcomes. Nursing care has itself evolved significantly over the years, and in the era when symphysiotomy was performed it operated under a strict system of rules and timetables. The Harding Clarke Report into Our Lady of Lourdes Hospital identified in addition a culture in which hardship was actively embraced, and believed by some to

add to the importance and value of the work being undertaken. In such environments, the mother's requests for pain relief, or worries about their ability to move, were often dismissed. There was a strong sense that the women just had to 'get on' with their recoveries: unlike surgical cases, they had 'only' given birth, and should 'pull yourself together'.²³⁹ There were some notable exceptions, and several women recalled the kindness of nurses and nuns involved in their care. One told of a young nurse who was close to tears when she helped her out of bed after the symphysiotomy. Another described the gentleness and patience of the nursing team who encouraged her to walk, and brought her baby to the bedside when she couldn't walk to the nursery.²⁴⁰

The most significant difficulties reported in the aftermath of the procedure were chronic pain, difficulties in walking, and problems with continence. The severity of each varied widely, and some of the immediate effects at least were due to the naturally stressful process of labour and birth. As one respondent wryly noted: 'It was my third delivery. I already knew about stress incontinence, piles, exhaustion, stitches, backache and all the other joys of birth!'²⁴¹ Indeed it was the fact that many symptoms were the same as that following a normal but difficult labour, which prevented women from asking the questions that might have revealed that they had a symphysiotomy. Despite much inaccurate and sensationalist media coverage of the procedure, it was not a secret operation. Medical notes recorded its use in each case, although most do not provide a great deal of additional detail.²⁴² Thus mothers who remained in pain for many months after delivery, and who were unable even to walk up and down their stairs at home, did not seek additional, specialist care: most thought that they had been through a normal, but very painful birth.

30% of the respondents used the same phrase with regard to the aftermath of the symphysiotomy: they 'had to learn to walk again.' Almost all of these women noted that they had not been adequately bound (some not at all), and they found even standing difficult. 'The next morning I was brought to the ward. I was not bandaged. I

²³⁹ All spoken to a woman in Drogheda in 1978.

²⁴⁰ Delivery in 1962.

²⁴¹ Delivery in 1976.

²⁴² Medical notes on the progress of labour and delivery are normally quite brief, recording factual data on the duration of labour, physical condition (dehydration, blood pressure etc), and interventions including forceps, episiotomy, symphysiotomy, caesarean section or blood transfusion.

was put out to walk. There were two nurses either side of me holding me under the arms. The nurse...was behind me kicking my right foot along. She said 'You will have to learn to walk again, you have had your pubic bone broken.' If she had told me anything I would have believed her as I was so naïve. I didn't ask any questions but I wasn't told anything either.'²⁴³ In two cases it would seem that premature mobilisation caused the partially healed joint to rupture: both women remembered hearing a 'pop' when they attempted to walk after the procedure, and having a sensation of 'collapse' in their pelvis. These injuries caused long-term pain and chronic illness. Mothers learned to adapt to the problems but the result was often another part of the body being placed under strain: 'I had to be trained to walk again and that took fourteen days in hospital...I suffer continuously with severe lower back pain, pains in my hips, acute incontinence and occasional depression. I can now manage my back pain fairly well.'²⁴⁴ 'Since then I have suffered constant pain in the pelvic area and hip and a stabbing pain down my left leg. I have suffered incontinence and depression to this day.'²⁴⁵

Another key failing was the discharge of women with little or no advice as how to manage the aftermath of the delivery. Several of the symptoms reported related to the difficulty of the delivery in general: in common with women who experienced prolonged and problematic deliveries unrelated to symphysiotomy, they suffered from pain, incontinence, and vaginal injuries. But the symphysiotomy women were unique in that they had had an intervention that altered their skeletal structure, and they should have had very specific guidance and support in the months following the procedure to ensure proper healing. It was known for example that no heavy weights should be lifted for a period of at least three months, but women reported being discharged from hospital after two weeks with no advice as to aftercare. One mother was a farmer's wife, who resumed her usual routine of heavy farm work after the birth. She found the process of milking in particular only manageable with the help of her other young children, who steadied her on the milking stool and helped to carry the full buckets.²⁴⁶ Ironically, one of the recommended tests for pelvic stability following symphysiotomy was the ability to carry a bucket of water without strain.

²⁴³ Delivery in 1973.

²⁴⁴ Delivery in 1971.

²⁴⁵ Delivery in 1966.

²⁴⁶ Delivery in

Others had chronic pain and persistent incontinence problems: 'I have had to wear pads all the time. My unstable pelvis wore down my hip. I had a hip replacement in July 2010 after five and a half years of severe pain. The pain is still there and has been since the operation and there is bone growing on bone.'²⁴⁷ 'The lasting effects of the symphysiotomy for me was years of pain. I could cope after eight years of pain but it was still there nonetheless. It resulted in me being incontinent since I was 29 years of age.'

The six-week check up after delivery is rarely mentioned in the respondent's accounts, so it is difficult to gauge whether symphysiotomy was discussed at that stage. Some women indicated that they avoided attending doctors whenever possible but do not state whether they attended their obstetrician for the usual check. Many did record that they were asked to walk up and down stairs at hospital consultations to monitor their gait: these women were presumably those who knew they had had a symphysiotomy. Given the unique nature of their intervention, one would expect that symphysiotomy would have been specifically mentioned at these consultations. Several mothers recorded that they had been alerted to the procedure by their own GP, or another obstetrician, and offered treatment, including surgery.

General Profile of Respondents:

The overwhelming majority of those who responded were married women, and delivered in Our Lady of Lourdes Hospital, Drogheda, the Coombe and National Maternity Hospitals, Dublin, and the Bon Secours Hospital, Cork. There were also respondents from Meath, Navan, Limerick and Galway, and others who came originally from other regions but who delivered in the hospitals above. Most were in their 20s, with the youngest aged 18 at the time of the symphysiotomy, and the oldest aged 40: the average age of women who underwent the procedure was 26.²⁴⁸ Two respondents experienced spontaneous symphysiotomies (where the symphysis pubis ruptured during pregnancy or delivery), one of whom poignantly noted: 'I have nothing to gain by telling you all this as this was my body's fault, but I would like to tell you how, after [-] years it is still affecting my health.'²⁴⁹ 20% of respondents were

²⁴⁷ Delivery in 1973.

²⁴⁸ Half of the women specified their age.

²⁴⁹ I am very grateful to these two women for offering their experiences as part of the consultation.

private patients, under the care of a range of obstetricians. 92% were married women, 3% were unmarried, and the remaining 5% did not specify marital status.

Almost one-third of respondents had the procedure for their first delivery. A further 14% had had either a normal delivery for their first baby, or a caesarean section, and had a symphysiotomy for their second child. There were several who had a number of normal deliveries, and then had a symphysiotomy for the births of their fourth, sixth, eighth and ninth deliveries respectively. In these cases, the explanation for symphysiotomy was breech presentation (in 2 cases); disproportion (1) and unknown.

8% of respondents stated that they did not have additional children after their symphysiotomy, with 3 noting specifically that the experience had been so traumatic that they did not want to endure another pregnancy and delivery. 40% went on to have one or more children (ranging from one to four) and the remainder did not state whether they had subsequent pregnancies and children.

There were in addition five respondents who had not had symphysiotomies, but had had traumatic deliveries. Two of these had caesarean sections that resulted in long-term illness (incontinence and chronic pain) and two had episiotomies²⁵⁰ that had healed poorly and caused chronic pain. The fifth was a patient who had had a caesarean hysterectomy in Our Lady of Lourdes Hospital and had not been part of the original compensation scheme proposed in 2007. Although these accounts could not be included in the summary of contributions, I wish to acknowledge their submission.

Support Offered by the Health Service Executive to Women who have had Symphysiotomies:

The HSE has a distinct and dedicated system of support for women who underwent a symphysiotomy. Following a meeting in late 2003 between the then Health Minister, Micheal Martin and representatives of the support group Survivors of Symphysiotomy, a support system was put in place with the following provisions:

²⁵⁰ Also known as a perineotomy, it is an incision on the perineum and the posterior vaginal wall during the second stage of labour. Routinely used in deliveries in Europe until the 1970s, when there was a prevailing belief that it was better to have a surgical cut rather than a tear that could be difficult to suture, it is now less common.

- **Liaison personnel** have been appointed in each region (former Health Board areas).
- **Information packs** have been made available to GPs and relevant healthcare personnel through the Liaison Officer.
- Patients who underwent a symphysiotomy have been granted **full GMS (General Medical Services) eligibility** on medical grounds and are issued, on application, with a specific patient identifier services card from the Primary Care Reimbursement Service (medical card type: SOS)
- **Independent clinical advice** is available, on request, through the Liaison Officer to patients who have undergone symphysiotomy and appropriate follow up fast-tracked.
- **Clinical assessments** and/or advice is offered to Symphysiotomy patients where requested, including a Home Assessment by an Occupational Therapist or Physiotherapist.
 - A refund of medical expenses directly related to symphysiotomy are made, where appropriate, to patients in respect of medication/ treatments recommended by their GP/Consultant required to address the effects of symphysiotomy.
 - Applications for home help and home modifications are dealt with on an individual basis and applications for home help are fast-tracked, where necessary.
 - Home help application is assessed by local PHN
 - Home modifications are referred to local County Council
- **A national triple assessment** service provided by a multi-disciplinary team consisting of an Orthopaedic, Gynaecology and a Urology assessment was established at Cappagh Hospital, Dublin in 2005. Following assessments, recommendations for care pathways were discussed and fast-tracked.
- **Independent Counselling Services**, including family therapy, is available to women, if requested, who have had a symphysiotomy
- **Clinical assessments** and/or advice will be offered to Symphysiotomy patients where requested, including a Home Assessment by an Occupational Therapist or Physiotherapist

- Appointments for follow-up care following assessments are **fast-tracked**, where possible
- **A support group** was set up in both Dundalk and Drogheda in 2004 – the Drogheda support group is still ongoing and meets once a month. This group is funded by the HSE and is facilitated by a qualified counsellor.

The Liaison Officers will also facilitate medical assessment, gynaecological assessment and counselling, and on the recommendation of GPs will assist in accessing complementary therapies including reflexology, physiotherapy, osteopathy and acupuncture.

Women who attended the consultations noted that the Liaison Officers offered a high level of support, often taking phone calls and fast-tracking services at weekends and evenings. The service in the North-East was rated particularly highly, and as a model for the remainder of the country: this is reflective of the fact that the largest number of women who have undergone the procedure are from this area. It is important that women are aware of the HSE services that are available to them, and that they secure the help that they require.

Impact upon Children:

With the exception of symphysiotomies performed in advance of labour, or those following immediately after a caesarean section (see 'on the way out'), many were performed in cases where labour did not progress satisfactorily. Women reported that they had endured lengthy and difficult labours, some for two and three days, and they were debilitated, dehydrated and exhausted. They were already therefore greatly stressed before the symphysiotomy was performed, and found that recovery after the birth was slow and painful. They were confined to bed and many were in any case unable to walk without assistance. In addition to the problems associated with the procedure, some women also suffered from vaginal tears, haemorrhaging, and other birth injuries that stemmed from prolonged and difficult labours. Time and again the women noted that they had difficulty bonding with their babies, a problem exacerbated by the fact that because of the nature of their deliveries, they were often unable to hold or nurse their children. Some were too exhausted to feel anything for the child. On being told she had a baby girl, one mother said "You can keep her."

That was how wretched I felt. In the following few days I seemed to drift in and out. My husband told me the baby was beautiful but I hadn't seen her and I had no interest in her. I think she may not have been too well after her own experience but nothing was said to me.' The experience of separation was shared by many women in this period who did not have symphysiotomies, of course: in the 1950s and '60s it was common for babies to be brought to their mothers only for feeding, and taken away again to let the mothers rest. Although contrary to modern best practice, it was believed to help establish a feeding and rest routine that would benefit both. But the physical effects of symphysiotomy often had a detrimental effect on the early days for mother and child, with 15 respondents reporting that they did not see their babies for periods of up to five days because they were recovering from the symphysiotomy and unable to leave their beds. Many of the births were traumatic even before the symphysiotomy was performed: one husband reported that 'our son looked like someone who had come out of a car crash and every time they moved the incubators to show him to my husband the baby would cry as he was so badly bruised.'²⁵¹

Five of the respondents raised the question of possible long-term impacts upon the child born through symphysiotomy. In these cases the children had physical and/or developmental problems, and the mothers felt a sense of worry and guilt over whether the difficulty of the birth had been the cause of this. Four noted that they had struggled to cope with the new baby, with three stating that the child was difficult to soothe and more prone to illness than prior or later siblings. The sense of guilt, however unfair or incorrect, impacted upon the relationships mothers (and in some cases, fathers) had with the children born through symphysiotomy, and continues to colour family dynamics many decades later.

Many children who attended the consultations noted that they had had poor relationships with their mothers, and were saddened at the fact that chronic illness had meant that their mothers were unable to engage fully with them – several noted that they felt their mothers were often 'away' (distant and disengaged) during their childhoods. The children born as a result of symphysiotomy reported that they often carried a sense of guilt and a feeling that they were in some way responsible for their

²⁵¹ Delivery in 1975.

mother's ill-health. The following response encapsulates the feelings and experience of many children, but also the understanding sometimes reached in adulthood:

...at times I felt responsible for putting my mother through such pain and wondered if she was still ambivalent towards me. It is only in recent years that the rest of my siblings have become fully aware and we have discussed her amongst ourselves. We do realise that her experience did effect her attitude and the advice she might give us. We also knew as children how extreme some of her fears were and we grew up fearful of doctors and dentists and authority in general...She has often talked of her fear of getting pregnant and of not being able to enjoy married life as much after the first year and how much she envies our generation and our level of knowledge and equality and our contraception!...We would like to see some acknowledgement of her suffering and distress.²⁵²

Other children reported that the physical impairment their mothers endured put a strain on their parent's relationship, which in turn impacted upon their childhoods. One felt that she was the cause of desperate unhappiness in the home, as she was born following a symphysiotomy: 'You see they saw me as the cause of all their woes and the destroyer of their sexual relationship as I know this was dreaded by my mother till she had a hysterectomy in her forties. I now know this symphysiotomy traumatised my mother and the relationship she had with my father. Pregnancy terrified her and the recent publicity about this operation opened terrifying memories which she has begun to speak about in a limited fashion.'²⁵³ Similarly one son indicated that 'my mother was always delicate and in poor health'²⁵⁴ and was remote from him and his two brothers, leaving them to the erratic care of their father. Other children felt a sense of oppression in the home, with a constant sense of helplessness over their mother's continual illness.²⁵⁵ Although not the literal survivors of symphysiotomy, the children born through the procedure, or brought up in a household with a mother suffering chronic illness as a result, were substantially affected by it. It is however heartening to see the pivotal role children play in supporting their mothers. Many of the attendees at the consultation meetings were accompanied by their daughters and sons, as well as daughters-in-law. They also

²⁵² Delivery in 1954.

²⁵³ Delivery in 1948.

²⁵⁴ Delivery in 1967.

²⁵⁵ Delivery in 1964.

helped with the submission of responses to the Draft Report, and with the transcription of personal experiences of the procedure. Despite the difficult nature of their births, they are clearly vital sources of support for their mothers.

Impact upon Husbands:

Husbands played a key role in supporting their wives following deliveries. The testimony from spouses is reflective of the prevailing contemporary culture: almost all of the men noted that they felt ill-equipped to deal with the aftermath of a process that was regarded very much as the women's sphere. The men who attended the meetings, and who submitted written testimony, were highly supportive of their wives and instrumental in seeking explanations for the use of symphysiotomy. However, many women noted that their husbands were uncomfortable with their discussion of the deliveries and births, and were reluctant to engage with it. This did not stem from indifference, but from embarrassment - in many cases, modesty limited any detailed discussion of what had happened during the delivery, and men felt reluctant to press their wives on a subject that clearly distressed them. Moreover, some were equally unsure as to what the problem was, and believed that their wives had undergone a difficult but normal labour. As one noted 'I did not understand what had gone wrong and was ill-equipped to give her the strength and support she needed at such a crucial time.'²⁵⁶ Another said 'Sure I hadn't a clue what to expect. I thought she was taking a long time to recover but I supposed it was because it was such a tough thing to do, to have a baby, so I didn't think to ask the doctor about it. Anyway in those days you didn't really ask questions, you just got on with it.'²⁵⁷

There was a striking similarity in responses from husbands that relate to a sense of retrospective shame that they had not pressed more forcefully for answers as to the progress and outcome of labour. Although most were very worried about their wives and children, they felt that, as one put it, 'it was really a woman's world, birth and that, we [men] didn't know what to do.'²⁵⁸ One father reported that he bitterly regretted not pressing the medical staff for detail as to his wife's case, and that he felt 'ashamed' in leaving her each evening in the hospital, unaware of what the

²⁵⁶ Delivery in 1973.

²⁵⁷ Delivery in 1967.

²⁵⁸ Delivery in 1968.

problems were.²⁵⁹ Some men, worried about the health of their spouse and child, wanted to press for detail but were persuaded against it by their already stressed wives: 'When my husband came in, he wanted to complain but I was so afraid, I just wanted to get out of there.'²⁶⁰ In this period husbands were not present in the delivery room, nor did they routinely take part in discussions regarding pre or post-natal care. Most were unaware for many years that their wives had had symphysiotomies, although some suspected that the delivery had not been a routine one, because of the very lengthy periods of recovery. In one case, a husband was informed by the obstetrician that his wife had undergone the procedure: the wife had not been told. In the immediate aftermath of the birth most husbands focused on their wife and the child, and believed that recovery was merely a matter of time.

Husbands played a key role in childcare after deliveries, along with mothers and mother-in-laws. In most cases women were grateful for the help, without which they couldn't manage, but were left with a strong sense of guilt that they were 'failing' as wives and mothers, unable to look after either their husbands or their children. Not all husbands were prepared to help, and became frustrated and hostile when the women remained in states of ill-health. One mother recounted how her husband used to mock her awkward gait in front of their children, and was impatient with her continual anxiety regarding incontinence.

The long-term consequences of symphysiotomy often included a great fear regarding sex, for two principal reasons. The first was that it was often painful because of pelvic instability, and some husbands felt a sense of guilt at putting their wives through such discomfort. '[--] was always very good, and never said she didn't want to, but it wasn't right after our first child was born. She was always very tense, you know, and I felt bad about it.'²⁶¹ The husbands who took part in the consultations were clearly key sources of support for their wives, even when they felt uncomfortable discussing the procedure or its outcome. Their wives recorded their deep gratitude towards them, and several noted their belief that they were fortunate to have had understanding and considerate partners, especially in the context of the times. 'A lot of men wouldn't have put up with that [reluctance to have sex]. They

²⁵⁹ Delivery in 1962.

²⁶⁰ Delivery in 1966.

²⁶¹ Delivery in 1961.

would have felt that you know, you have to just get on with it, and it wouldn't be fair not to do it. I know that I was very lucky that [--] never forced me when I wasn't able.' The other great fear was of falling pregnant again, when they were still in pain. The dread of the delivery following a symphysiotomy was great, and several women were pregnant within six months of their procedure. 'I spent those nine months in absolute terror. In the end the birth was all right, but the fear ruined the whole pregnancy for me.'²⁶²

Continence issues limited the lives of many women for varying periods after the birth. This had an impact upon the lives of husbands in that it reduced the range of social activities undertaken as a couple. Many who had enjoyed physically demanding sports, or dancing as a couple, were now severely restricted, and although some eventually recovered well and resumed active lives, some did not. Women felt badly on their own behalf, and guilty on behalf of their husbands, who had to adapt to these restrictions. One reported that she had never had a holiday abroad, as she was too anxious about continence and mobility problems to risk it: she poignantly noted that as a result her husband had never flown either.

Recommendations:

Apology: A continually reiterated point at the consultations and in the submissions is the question of an apology, and survivors have stressed the importance of a public acknowledgement of regret for the procedure's use. It is important to note in this regard that three significant public apologies have been made to date. The first was by the Medical Missionaries of Mary in February 2010:

During the period when the Medical Missionaries of Mary owned the Hospital, symphysiotomy operations were carried out solely at the discretion of the obstetricians involved. The Medical Missionaries of Mary always expected that any procedure in the hospital was carried out for good clinical reasons. The incidences of these procedures were recorded in the Annual Report of Our Lady of Lourdes Hospital, Drogheda which was published and furnished to the Department of Health and the Institute of Obstetrics and Gynecology.

The Medical Missionaries of Mary deeply regret any hurt and/or

²⁶² Delivery in 1961.

trauma sustained by women who underwent symphysiotomy at the time of delivery of their baby in Our Lady of Lourdes Hospital, Drogheda.²⁶³

The second is from the Institute of Obstetricians & Gynaecologists of the Royal College of Physicians of Ireland, also in 2010. Its website currently reiterates this original public statement, offering 'our unreserved sympathy and support to any mother who may have experienced complications following symphysiotomy'.²⁶⁴ The Institute works with Survivors of Symphysiotomy Ltd, individuals who had had the procedure, and with the independent patient advocacy group Patient Focus, to assist women who have suffered, and continue to suffer, complications as a result of the procedure. It should be noted that the IOG was established in 1976, and its creation therefore post-dates the majority of symphysiotomies in Ireland. It did not have overview of the practice because it did not exist for the majority of them: the later symphysiotomies are the exception. The third apology was made by the then Chair of the Institute, Dr. Michael O'Dowd. On a 'Primetime' programme on symphysiotomy broadcast on June 14th, 2012, Dr O'Dowd apologised on behalf of the Institute to any woman who had experienced adverse effects as a result of the procedure.

The IOG has taken proactive steps towards addressing the issue. In 2003, the then Chair wrote in support of women who had suffered adverse outcomes from the procedure, and recommended a full explanation. In 2010, the Institute offered to facilitate the publication of women's experiences of symphysiotomy, an initiative that could well be an important part of this overall process, in 'aiding the healing process (see IOG role below)' between survivors, and between the public and the profession. Some survivors have emphasised the importance of including the medical profession in any resolution, and recognise the problem in condemning the whole body as a result of symphysiotomy:

I would like transparency. I...would like the truth to come out...I would like the obstetricians to be vindicated, because I feel – I feel that [they are] being tagged by a few bad apples in the bag, you know, from the past. I think they're afraid to come out and tell us

²⁶³ Medical Missionaries of Mary Press Release, *Drogheda Independent* February 23rd, 2010.

²⁶⁴ See the IOG website for the full text of the Institute's position on symphysiotomy at <http://www.rcpi.ie/article.php?locID=1.11.30&itemID=100>.

the truth, but they shouldn't be afraid to come out and tell us the truth. We're willing to meet with them; we're willing to sit down with them.²⁶⁵

This process has already begun on an informal basis, with obstetricians from the IOG meeting with survivors to discuss the procedure and its outcomes. The erosion of confidence as a result of symphysiotomy was an issue that arose repeatedly at the consultations, with attendees discussing the importance of dealing directly with health professionals. Many reported that they had had a life-long fear of doctors and hospitals as a result of their symphysiotomy, and found that meeting with obstetricians in a neutral environment had helped considerably in removing what one called the 'shadow' of anxiety. This initiative clearly has the potential to contribute significantly toward a restoration of confidence on the part of the women in the medical profession. It also has the potential to reassure the general public that modern medical practice is capable of recognising failures in care when they occur, and acting to remedy them. Patients frequently engage with health services when they are at their most vulnerable, and it is vital that they are confident of receiving the best possible care.

Role of the Institute of Obstetricians and Gynaecologists:

Phase two of this study found that the role of the Institute of Obstetricians and Gynaecologists (IOG) has been consistently and alarmingly misrepresented, causing a popular perception that it was unwilling to address the issue. In fact, the IOG has proactively sought a resolution from the outset, and offered professional assistance in explaining the procedure to survivors. A letter from the then Chair of the IOG in May 2001 to the Chief Medical Officer summarised the historic use of the procedure, and indicated the conditions under which it declined: at no point did the letter claim that it was the norm in cases of obstructed labour. In 2003 the then IOG Chairman wrote in support of women who had had the procedure, stressing the importance of a full explanation, and stating that their ongoing medical and psychological issues should be treated sympathetically. In 2010 Minister Harney requested the IOG to provide a report on symphysiotomy, and a report team that included SOS, Patient Focus, and members of the IOG met to discuss terms of reference. The intention was to produce a report that would include interviews with women who had

²⁶⁵ Quoted in Jillsen, *Symphysiotomy*, p. 20.

undergone the procedure, as well as an examination of the long-term outcomes. However, the constitution of the report team was criticised, and the members subsequently elected not to proceed: it is certainly unfortunate that this effort failed (and indeed the even earlier attempt by the Department of Health to commission a single-authored study – see p. 11 of Draft Report), as it would have offered a resolution at a much earlier stage, and included those women who have sadly passed away in the interim.²⁶⁶

The Institute of Obstetricians and Gynaecologists have specified the roles they will play in producing the best outcome for survivors, by:

- Advocating that the mothers and their families are given a full explanation, to which they are entitled, that their grievances are considered sympathetically and in full, and that their voices are heard and supported throughout this process.
- Encouraging all those involved in women's health to participate in the consultation process as outlined by the Chief Medical Officer
- Aiding the healing process between the public and the profession by meeting mothers and their families to talk through the experience
- Supporting the Health Service Executive, the Department of Health, and advocacy groups in their initiatives to assist those who have suffered complications of the procedure
- Ensuring that data on symphysiotomy is incorporated into a national clinical audit on obstetric practice
- Encouraging a 'Needs Assessment' and study of those who have suffered complications of the procedure in Ireland²⁶⁷

Contribution to Medical Knowledge:

Many of the respondents raised the possibility of using the process as a means of advancing medical knowledge. Because symphysiotomy was revived in Ireland at a time when it was in sharp decline elsewhere in Europe and the western world, the medical literature that exists for the procedure comes for the most part from the

²⁶⁶ The team was to have included a psychologist specialising in post-traumatic stress, a urologist, and an obstetrician, all from outside Ireland.

²⁶⁷ Submission to consultation process, July 13th, 2012.

developing world. There is a unique opportunity, with the help of survivors, to compile data on the long-term effects of symphysiotomy that could inform the practice elsewhere. The women repeatedly stated that they wished their experiences, although negative, to have some beneficial outcome – not least in preventing the practice being used in other countries, given the negative impact it had upon their lives. This could easily be done as part of the needs assessment process, and would be a valuable part of the resolution process.

Redress:

The Government, through the Health Service Executive, is actively assisting women who have had symphysiotomies through the dedicated system of support outlined above. This ensures that women are facilitated in seeking specialist medical care and treatment, and support in the modification of their homes, if necessary. They are eligible for medical cards, and for fast-tracked assessment and treatment as appropriate. This is a vital element in addressing the many side-effects of the procedure and assisting the women towards the fullest possible enjoyment of their lives, without burdening them with excessive costs. It is important that this system of support is maintained, and that all women are made aware of their entitlement to it. The Liaison Officers have done vital work in ensuring that women access these sources of support, and this has made a great deal of difference to the quality of survivors' lives.

However, many women who underwent symphysiotomies have had their lives substantially impaired as a result. All of them are in their late middle age, or elderly, and time is against them. Those who contemplate legal action for redress will face a series of lengthy court struggles – a recent case taken against Our Lady of Lourdes Hospital with regard to a symphysiotomy took ten years to reach a final decision in the Supreme Court - with a very uncertain outcome, substantial legal bills, and the significant stress of court appearances. In light of these pressing circumstances it would be appropriate for the government to establish an independent specialist needs assessment team to evaluate the cases, and advise on the care requirements of each woman. This was done in 2005 and had a limited take-up from survivors (22 women came forward for assessment), but would now offer the assurance of rapid action. There is a large range of impairment within the cohort, from no adverse

effects through to significant disability, incontinence, mobility problems and chronic pain, resulting in substantial differences in terms of the limitations placed upon individuals as a result of the procedure. It would be appropriate therefore for a Board to determine suitable levels of compensation for those with clear adverse effects from their symphysiotomy. The total number of women concerned is relatively small, and it would be possible to put in place compensation at an appropriate level for each individual in a far more rapid and effective manner than through the usual expensive and lengthy courts process. There is broad party support for the resolution of this issue, as well as high levels of interest in the general public. Such a structure would resolve this long-running problem swiftly and efficiently, and reflect the general concern felt on behalf of this group.

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